	ian	Decedent's Name (First, Middle, I	Last)		10/0000		2. Date of Dea	ath Dav	Year	3. Time of D
Physic: /Medi		Mary E	LEANOR		wagne	$\mathcal{N}_{}$	July	29 0	2004	14.29
Exami		4a. Facility Name (If not institution, s	1/1// - 4/-	01/ 46.	City, Town, or Loca	tion of Death	11.11	4c. Cou	nty of Death	
		F Social Security Number	Sex 7. Age (In vrs.	last birthday) If U	nder 1 Year If U	10/2 (Inder 24 Hrs.	179		O Bish	-la-a- /Chata au
Funeral Director		5. Social Security Number 6		Yrs. Mor		urs Min.	(Month, Da)	y, Year)	Soul	
		Usual Residence of Decedent					09/16/1	94/	fen	nsylva
ehow ad et		10a. State 10b. County	10c. C	ity, Town or Location	1					10d. Inside City
la-f	Sto	VA FRAN	Klini	Chambe	156419					1 Tes 2
au wu ue mayra s 23a or 28a-f ehov usi be noilled at	Dire	10e. Street and Number	`	10	f. Zip Code			. 151	of What Cou	ntry?
ns 23a or 28a-1 ehow	-a	3151 St. 1	Andrews DI	ive	1720			113		
	Funeral Director	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	If Yes,	ecedent of Hispani specify Cuban, Me	ic Origin? (Sp exican, Puerto	Bican, etc.)	14. F	Race - Americ Black, White,	
, or	ě	3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 Mo If Yes, Give Year or Dates:	1 🗆 Y	es 2 No Spe	ecify:		Spe	city: W	hite
"natural", or its	Completed	15. Decedent's	Education	16a. Decedent's	Usual Occupation		hi	16b. Kind o	f Business/In	dustry
- 138	pie	(Specify only highest (Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	of work done during OT use retired)	most of won	king	Lux	Lern	-
Hygiene. other than	ပ္ပ	12	4	Execust	ve Dire				Serv	ices
	Be	17. Father's Name (First, Middle, La	,			-	ne (First, Middle,			
d Menta markad matic ev	မ	John A	4. HANE	4		CLYN	12,2	TIER	rity	
a = 1		19a. Informant's Name/Relationship		19b. Mailing Add	iress (Street and N	-		er, City or To	wn, State, Zip	Code)
Health Iem 27 other tr		20a, Method of Disposition	19 m E.C 20b. 1	Place of Disposition	Name of	2607	Date	20c. Locatio	on - City or To	own State
nt of Hear : If item		1 ☐ Burial 2 ☐ Cremation 3	Themoval nom State	Place of Disposition cemetery, crematory					i i	1
Department Important: eny injury c		 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice 		Mberland	o and Admos of E	Cocilibe	131/04		resbor	o Pr
Depa Impo eny ii		De la la	F.	Doug	5/15 A. 1	riery	Funeral		-01	4.19.4
		23a. Part 1. Enter the disease, or co	emplications(that caused the dea	th. Do not enter the	mode of dying, suc		or respiratory ar	rest,	Md	2174 Approximate
inia		shock, or heart failure. List on Immediate Cause (Final	lly one cause on each line.		, ,					Interval Betw
hysician			11 / 1+ 10 1/ 11	Mi ata	Dichy	000	100	NAAA		Onset and D
/Medical		disease or condition resulting in death)	a. Acute RS	plivator	1 Distra	2555	yndr	Me		Onset and D
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xaminer	ner	disease or condition resulting in death)	b. Due to (or as a consec	quence of): Ny CLG(quence of):	1 Distra	ess S Leuk	yndr cenn a	eWe	-	Onset and D
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Deat 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:35 AM Artis 2004 August **Physician** James 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 24 Hrs. 7. Age (In yrs. last birthday) Number Hours Days 100M 2□F 59 **Funeral** 246-66-1388 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County death with the Maryland 10a. State Yes 2 No Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumstic event, it a Madical Examiner must be notified at Baltimone Director MD 10g. Citizen of What Country? 10e. Street and Number 21231 ay effe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 120 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iter any Injury or other traumatic event, it a Medical Expedition 1□ Yes 2 No 1 Never Married 2 Married Specify: Black Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Trucking Elementary/Secondary (0-12) College (1-4or 5+) Truck agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evans Lrene James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 222 N. Spring Court Battmone, MD 2123 Sanders Alberta 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 12/04 Lans Downe 1 Ce Zvan *4 □ Donation 5 □ Other (Specify) sentry 21. Signature of Fundral Service Licenses Baltmore MD 21201-192 709 Tessler once. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): embolism Physician /Medical Examiner Venous Deep Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner to (or as a consequence of): The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Spastic Division of Vital Records, P.O. Box 68760 T-cell by Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death Month Year 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Ponknown failure 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Be Completed 24a. Was an performed? page 2 1 Yes 2□ No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifical 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ▼No To 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number City or Town, State) 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by the 6 Could not be determined 3 🗌 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier medical RES - 000

DHMH 17 Rev 1/2001

State

Registrar

Some

Street

Doctor

600 North Wolfe

32. Pagistrar's Signature

Bultimore, Maryland 21287

M. Leber

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Gerber

AUG 13 2004

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:15 pM Mary E. Allen 2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore Joseph Richey Hospice 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2√2 F 93 216-28-5169 Yrs. Director 1910 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at Baltimore 1 □Yes 2 No Director Baltimore Maryland 10f. Zip Code 21229 10e. Street and Number 10g. Citizen of Whal Country? 207 Westshire Road United States Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural" or inspirity or other treumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: White Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Westinghouse unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Wright Harry J. Novotny 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Bradley / Cousin 163 Falcon Drive, Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Removal from State 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 8/9/2004 Woodlawn, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or compitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final Priysician Cerebrovascu ~ I Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury the attending physician and the for use as the burial-transit requires that the death certificate be executethat initiated events resulting in death) Last Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnanl at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has perform rmed2 2 No certificate Yes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 4No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number August 5, 2004 erson who completed cause of death (Item 23a) (Type, Print) Baltimora MD E.TSO MD Hospice 838 NEW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 3 2004

DHMH 17 Rev 1/2001

MARY ALLEN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Genevieve Augustyniak 2004 Aug 10:05A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Hall Middle River Baltimore Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 218-18-6959 89 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at Md. 1X Yes 2 No Director n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2025 Fleet Street 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Press Operator National Can Compan permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hygis
Important: If Item 27 is marked other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Korowski Laura Gosh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Augustyniak(son) 406 South Eaton Street Baltimore, Md.21224 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St.Stanislaus Cem 8-11-2004 Baltimore, Maryland injury or * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee any 1201 Dundalk Avenue Balto., Md.21222 ic La 23a. Part 1. En ar the disease, or a implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List, only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Programa **Physician** /Medical Due to (or as a consequence of): **Examiner** 80 hore fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Brase Due to (or as a consequence of): 9 Physician/Medical certificate ass altending IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 5 Other (specify) P.O. I the a detached 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate Division of Vital 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 HNo Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) After ti 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending after death.

Director: Aft investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in foth: within 24 hou. * the Funeral D' 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D031464 9104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shoaib A. Hashmi. M.D. 821 N. Eutaw Street, Suite308 Balto., Md 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 3 2004

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:05 P M 09, 2004 August Beato Corro Alvez /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1200 Pinefield Court Edgewood If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1₩ 2□ F Philippines May 10, 1908 Director 96 218-10-7564 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State in than "natural", or Itams 23a or 28a-f ahow The Medical Exercipes must be notified at 1 ☐ Yes 2 ☑ No Edgewood Maryland Harford Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 1200 Pinefield Court 21040 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, should be filed within 72 hours after de Yealth and Mental Hygiene.

m 27 is marked other than "nature" 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Philippino Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security +4Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Aquida Corro Miguel Alvez ပ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 1200 Pinefield Court, Edgewood, Maryland 21040 Lauri Peregrino - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8/12/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Scared Heart of Jesus 22. Name and Address of Facility 21. Signature of Funeral Service Licensee David J. Weber Funeral Homes, P.A. 401 South Chester Street, Baltimore, 21231 Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death todominal Immediate Cause (Final oneyear **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 No Division of Vital Records, P.O. 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Myocardia 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No stroke 24a. Was an interction autopsy performed disease 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case ferred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death Check on one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred in by the funeral 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baldimore 10 NOVEL OLVIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State of Maryland /		artment of I		d Mental Hy	/giene Reg. No)	Di PEROC
	Physici /Medic		Decedent's Name (First, Middle, Last) Derek Matthew Angel				2. Date of D Month AUGUS	Day	Year 04 5:05P. M
1	Examin	er	4a. Facility Name (If not institution, give street and number) 507 Glenbrook DRive		4b. City, Town, of MIDDLE	NWO.		4c. County FREDE	RICK
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B Min. (Month, D	Day, Year)	9. Birthplace (State or Foreign Country) Tennessee
, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours atter death with the Maryland I Health and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it e Mcdical Examinar must be natilized at	To Be Completed by Funeral Director	(Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Jonathan Mark Angel 19a. Informant's Name/Relationship (Type, Print) 19	a. Deceder (Give life.)	10f. Zip Code 21769 Was Decedent of If Yes, specify Cub I Yes 2 No dent's Usual Occup kind of work done DO NOT use retire nt	pation during most of during most of displayed by the second seco	? (Specify Yes or Nuerto Rican, etc.) working Name (First, Middl arie Shar	Specify 16b. Kind of Bi College e, Maiden Suman ndor ber, City or Town,	ce - American Indian, ck, White, etc. White usiness/Industry
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item 3 any injury or other once.		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State	of Dispo ery, crer Live	esition (Name of matory or other pla t Cemete 2. Name and Addro	ry 8/	7/2004	Frederic Basford	City or Town, State ck, Maryland l Funeral Home
Box 68760,	death certificate be executed Wedical e attending physician and dor use as the burial-fransit	n/Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and cause (Disease or Injury that initiated events resulting in death) Loue to (or as a consequence of the consequence of th	e of):	D OF	NECK			Interval Between Onset and Death
Records, P.O. Bo	aw requires that the ts been signed by th 2 should be detache	Completed by Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting	5 🗆	JEctopic pregnand Other (specify) _ ndertying cause gr		1	tobacco use cont Yes 2 No	onth Day Year tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
Division of Vital R	or Attending Physician: Thater death. Director: After this certificate in by the funeral director, pag	Certification; To Be Cor	25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 X Suicide 6 Could not be determined 28a. Date of Injury 28b. (Month, Day Year) 812-10 Young 1000 1000 1000 1000 1000 1000 1000 10	Time o Injury	f 28c. Inju	her: 4 Nursi	Death (Check only ng Home 5 Res 28d. Describe 5 VIST 6 C	2 No rone) sidence 6 X Oth how injury occur T CUT W (Street and Numbown, State)	11€ Yes 2 □ No ner (Specify) SCENE
•	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled, 2 Medicel Examiner: On the basis of examination a and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	and/or in	29c. Licen O • (se number C.M.E.	occurred at the time	29d Date signe AUGUST 3	and due to the cause(s) Ind (Month, Day, Year) 3 , 2004
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature		III Penn	street	, Baltimo	ore, Mary	rland 21201

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State Unpend Item #2	/3a-h // /8s	a-f Per	· me lakta	~4 <i>17.11</i>	O/L tag	0/	201	
		Registrar 1. Decedent's Name (First, Middle, Last)	134 5,27,200	- Lei	uncate of 1	Jeath '	2. Date of Dea	ath		3. Time of Death
Physicia /Medic		Lucila C. Arengo					August	06,	2004	23:03 M
Examin		4a. Facility Name (If not institution, give stree			4b. City, Town, or			4c. Co	unty of Death	
		Johns Hopkins Hospi		Jana to laste day of	Ball	timore			O. Diab	olana (State or Familia
Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. 88		Months Days	Hours	Hrs. 8. Date of Birt Min. (Month, Day July 19	y, Year) 3.1916	Phil	place (State or Foreign ntry) .ippines
		Usual Residence of Decedent					1002) 23	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
rylan show	_	10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 No
the Marylar 28a-f show	ecto	Maryland Baltimore	W	lood1aw	1			10- Citing	of What Cou	
with t	Dir	10e. Street and Number 2017 Greengage Road			10f. Zip Code 2124	4. /.			.S.A.	illy:
death ms 23	era	11 Marital Status 12. V	Was Decedent Ever in U.	.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)		Race - Ameri	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, if a Madical Examiner was the notification.	by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 🖾 No If Yes, Give		r Yes, specity Cuba 1220AYes 2□ No	Caraif			Black, White, ecify:	
nours ural',	d by	3 ♠ Widowed 4 □ Divorced	Year or Dates:			r ·	ilipino		Asi	lan
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id 2 should be filed Ith and Mental Hyg 27 Is marked otha traumatic event,	3e C	17. Father's Name (First, Middle, Last)					s Name (First, Middle,	Maiden Su	тате)	
Menta Menta arked atice	To Be	Martin Calambro					ia Abunday			
12 sh n and r Is m raum		19a. Informant's Name/Relationship (Type,			-		or Rural Route Number			
1 and Health am 27		Lolita A. Heimbach (PUTTY H1. psition (Name of matory or other place)		nue Towson Date		y Land 2 ion - City or T	
permit. Pages 1 ar Department of Hea Mportant: If itam any injury or othe		1 🖾 Burial 2 □ Cremation 3 □ Remo `4 □ Donation 5 □ Other (Specify)	oval ilolii State		matory or other place National		-24-2004	Arline	rton T	Jiroinia
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		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ons that caused the deat ause on each line.	th. Do not en	er the mode of dyin	ng, such as c	ardiac or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Hemopericar							Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseq Cardiac in of tachycar Due to (or as a conseq	uence of):	ring pace	emaker	placement	for	treatm	ent
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
ite be executed ysician and ne burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):						
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death certificate be executed e attending physician and of for use as the burial-transi	/Med	IF FEMALE: 23c	If yes, outcome of pregna	ancv				230	I. Date of deliv	ren/
atten I for u	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	aldeath 3[Ectopic pregnancy Other (specify)	/		200	Month	Day Year
that the de led by the a detached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
law requires that the as been signed by the 2 should be detache	by P	Part II. Other significant conditions contrib	outing to death but not res	sulting in the t	inderlying cause giv	ren in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
w require been sig should b							1	Yes 2 1	No 3 ☐ Pro	bably 4 Unknown
The taw requires to has been signed age 2 should be considered.	Completed						24a. Was autop	SV	prior to co	opsy findings available empletion of cause of
_ a o	Con						1 Yes	rmed? 2 □ No	death?	2 🗆 No
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Phy r this ral d	.: To	X Tes 2 NO	28a. Date of Injury (Month, Day Year)	ER/Outpatie	III JU DON	401401	sing Home 5 Resi	how injune	ccurred	
Attanding Ir death. sctor: After by the funer	tion		(Month, Day Year) 8/6/04	unknov		rk? Yes 2. ∑X N	cardiac	: ıntu	ry ass	ociated wi
Attandir death.	100	a □ a · · · · · · · · · · · · · · · · ·	28e. Place of Injury - At h	nome, farm, st					Jumber or Run	ral Route Number,
	125		operating s	suite			Hospital	, Bal	timore	, Maryland
ital or irs afte rel Dira led in b	Certification;		am. To the boot of much	owledge, dea	th occurred at the tir	me, date and	I place, and due to the h occurred at the time,	date and pl	d manner as	stated.
Hospital or 4 hours afte Funerel Directed in East of February (1997)		29a. Certifier 1 ☐ Certifying Physici. (Check only 2 ☐ Medical Examiner:	: On the basis of examina	ation and/or ii	ivestigation, in my c	pinnon, does			200, 2	to the cause(s)
o tha Hospital or ithin 24 hours afte o the Funerel Dira ompletely filled in t	Medical Certif	(Check only 2 Medical Examiner:	On the basis of examination and manner stated.	ation and/or ii	29c. Licens				signed (Month	
in Direct		(Check only 2 Medical Examiner:	: On the basis of examina	ation and/or ii	29c. Licens			29d. Date s	signed (Month	, Day, Year)
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To tha Hospital or within 24 hours afte To the Funerel Dirt completely filled in I	Medical	(Check only 2 Medical Examiner: one) 29b. Signature and title of certifier 30. Name and address of person who comp	On the basis of examina and manner stated.	3 m 23a) (Type 111	29c. Licens O, Print) Penn St	c.M.E	•	29d. Date s	signed (Month,	Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan	d / Department of F Certificate of		, ,	0001	0000
			Registrar 1. Decedent's Name (First, Middle, Last		Certificate of	Dealii	Reg. 2. Date of Death	No.	3. Time of Death
	Physici			. ^	ewer		Month	Day Year	17:39 M
>	/Medic Examir		4a. Fecility Name (If not institution, give			or Location of Death	· dold?	4c. County of Death	17.01
			Sinai Itospi	tai of Ba	Himore Bal	himore c	ity	N/	4
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. I	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthi	place (State or Foreign
	Director		219 - 90 - 760 2 Usual Residence of Decedent	39	Yrs.		Janvary 17	1965	MD
	show		10a. State 10b. County	10c. City	, Town or Location				IOd. Inside City Limits
	Many a-f sh	ţo	MD N/A	4	Baltimone				1 → Yes 2 No
	ith the Maryle or 28a-f shore	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
	23a	rail	2503 VVO	let Avenue		215		USA	
	Itema Itema	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.: Armed Forces?	S. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto i	ecify Yes or No- Rican, etc.)	14. Race - America Black, White,	
336	hours after tural, or its	by F	3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ƊMo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: B	ack
21215-0036	C1 0 1	ted	15. Decedent's Edu	cation	16a. Decedent's Usual Occup	pation	16b	. Kind of Business/In	dustry
215		Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	during most of workii d)	ng	~	
	be filed withintal Hygiene. Id other than event, ILE M	S	1259		Ivave			ENCO	ce
and	Ibe fi	Be	17. Father's Name (First, Middle, Last)				(First, Middle, Maid	4	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, ILE M	2	19a. Informant's Name/Relationship (Ty	wer	19b. Mailing Address (Street	BeH	7		Codel
Ma	s 1 and 2 should I Health and Men Item 27 is marke other traumatic		Jane Raule	/< > +000	2-U5/) A		ms Lan	y or rown, state, zip	nton MO 2111
re,			20a. Method of Disposition	1 00	ace of Disposition (Name of ometery, crematory or other pla	D		Location - City or To	
Baltimore,			1 ☐ Surial 2 ☐ Cremation 3 ☐ F 1 ☐ Other (Specify)	emoval nom State	+. Rest	8/14	104 1	Fenoven	un
alti	permit. Page Department Important: Il any Injury or once.		21. Signature of Furieral S. vice Licens		22. Name and Addre	ss of Facility	Finen		ce, PiA
_	90 E 2 9				Thysis Te	ssiers	Butter	word MD	21201-13215
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequent)	hemorragence of):	1	rrespiratory arrest,		Approximate Interval Between Onset and Death
876d	icale be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	myelom	<u>a · </u>			
9	ding p	/Me	IF FEMALE:	3c. If yes, outcome of pregnar	2004				
.O. Box	that the death certific ed by the attending p detached for use as i	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4☐ Pregnant at time of de 9☐ Unknown	death 3 Ectopic pregnancy	у		23d. Date of delive Month	ory Day Year
s, P	S U 0	by P	Part II. Other significant conditions cor	stributing to death but not resu	lting in the underlying cause giv	ren in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
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H H	That are pag						performed	death?	2 No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatient 200 DOA Oth	26. Place of Death			
of	Phys r this sral dii	.: To	1 ☐ Yes 2 ☑ No 27. Manger of Death	1 Lerinpatient 2 L 8	A DOA	4 Li Nursing Hon	ne 5 Residence	6 ☐Other (Specification)	/)
ion	Attanding Fr death. sctor: After by the funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wor	k? Yes 2 □No		,,	
Division of	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, street, factory, office	2	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	he Hospi n 24 hour he Funer pletely fill	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Exemin	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death occurred at the tir on and/or investigation, in my o	me, date and place, a pinion, death occurre	and due to the cause and at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier		29c. Licens	-		Date signed (Month,	Day, Year)
	. 1		Macli	o, MD	RE	7-000	Au	gust, 10	2004
	\		30. Name and address of person who co		23a) (Type, Print). SINAI Itasi	nitra al	- Bultin	100	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Signat	- 100	11111 0	DUTTIN	WIC .	
	Registr		ALIC 1		h 1				

Physic	ian_	1 - State Registrar AMEND ITEM# 1. Decedent's Name (First, Middle, Last	5 PER FH G83	34 8/19 9	artment of F	Death	2. Date of Death	. No 200	3. Time of Death	
/Medi Examir	cal	James Richard 4a. Facility Name (If not institution, give Johns Hopkins Bo	street and number)	r.	4b. City, Town, o	r Location of De Baltimo)	August	9, 200 4c. County of De	eath	
Funeral Director	300	Social Security Number 6. Se		yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 H. Hours Mi	rs. 8. Date of Birth	1921 9. E	Birthplece (State or Fore Country) Maryland	
28a-f show offilied at	ector	10a. State 10b. County Maryland N/ 10e. Street and Number		. City, Town or Lo	Balti	imore			10d. Inside City Lin	
Department of Health and Mental Hygiene. Importent: or Items 23e or 28e-f show any injury or other traumatic event, I're Medical Examiner must be notified at once.	Funeral Director	4717 Chatford Ave.	12. Was Decedent Ever	in U.S. 13.		21206 ispanic Origin?	(Specify Yes or No-	A. merican Indian,		
natural', or li zical Examin	by	1 Never Married 2 Married 3 Nowled 4 Divorced 15. Decedent's Edu (Specify only highest grad	1 X Yes 2 No If Yes, Give Year or Dates: 1942	1 ☐ Yes 2 No	Specify:	16	Specify:	Black, White, etc. Specify: White b. Kind of Business/Industry		
Hygiene. other than "i ent, I'm Max	Be Completed	Elementary/Secondary (0-12) 10th Grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life.	Cable Ope	erator	ame (First, Middle, Ma		Electric	
and Mental Is marked o sumstic eve	ToB	Patrick John Burk 19a. Informant's Name/Relationship (7)	ıora Seton	ŕ						
nent of Health ent: If Item 27 ury or other to		James R. Burns, 2 20a. Method of Disposition 1 \$\mathbb{M}\$ Burial 2 \(\text{Cremation} 3 \) \(\text{F} \) 4 \(\text{Donation} \) 5 \(\text{Other} \((Specify) \)	20 Jemoval from State	b. Place of Dispo cemetery, crei	Daybreak sition (Name of natory or other plac Cemetery	е)		c. Location - City of	or Town, Stete	
Departme Importer any injur		21. Signature of Funeral Service Licens	2/2004 Bo Lhimunek Fu Baltimore	neral Ho , Maryla	mes					
nysician Medical Kaminer		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the done cause on each line. Due to (or as a con				r		Approximate Interval Between Onset and Death	
hysician and the burial-transit	licai Examiner	Sequentially "st non-fittions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con:	· ,						
attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	alivery Day Year	
been signed by the should be detached	leted by PI	Part II. Other significant conditions cor	ntributing to death but not	resulting in the ur	nderlying cause give	n in Part I.	23e. Did tobacc	9 /	to the cause of death?	
ate has page 2	e Comple	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2	prior to death?		
After this funeral di	ertification; To B	examiner? 1	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 ☐ Nursing I	ath (Check only one) Home 5 The sidence 28d. Describe how in		acify)	
within 24 hours affer deal To tha Funerel Diractor: completely filled in by the	O	3 Suicide 4 Homicide 29a. Certifier (Check only) 2 Medical Examin	28e. Place of Injury - A building, etc. (Specials: To the best of my keeps, On the basis of average.	(nowledge death	occurred at the time	e, date and place	28f. Location (Street City or Town, St	ate)		
To the Fi	Medical	29b. Signature and title of certifier	ner: On the basis of exam and manner stated.	ination and/or inv	estigation, in my opi	nion, death occi	urred at the time, date a	and place, and du	th Day Years	
7							1			

			For	partment of Health and M	lental Hygiene	
				ertificate of Death	Reg. No.	25510
	Physicia	an	1. Decedent's Name (First, Middle, Last) Brathuhn		2. Date of Death Month Day 8th Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	14.
	Examin	er	University of Moryland MedicalCe	ator Baltimore	1 A D //	ore City
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda			thplace (State or Foreign
	Director		220-53-4075 ¹ ¼ ^M ² □F 5 Yrs.	World's Days Hours Will.	8. Date of Birth (Month, Day, Year) 9. Bird Co Feb 22, 1999 Mar	yland
	and w	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Many -f sho	호	Maryland Carroll	Manchester	<u>-</u>	1 ☐ Yes 2 ☑ No
	r 28e	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show ideal Epaninal must be notified at		3845 Millers Station Road	21102	USA	
	tems	Funeral	Amed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.) 14. Race - Ame Black, Whit	
36	rs afte	by F	1 ∏ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	white
8	2 hou atura cal E	ted	15. Decedent's Education 16a. Dec	cedent's Usual Occupation	16b. Kind of Business	Industry
215	ji	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working DO NOT use retired)	School f	
21	be filed within tal Hygiene. d other than event, the Me	Son	n/a	Student	the D	eaf
and	D = D =	Be	17. Father's Name (First, Middle, Last) Donald M. Brathuhn Sr.		(First, Middle, Maiden Sumame) Beline E. Weber	
Maryland 21215-0036	T D E E	ဥ		iling Address (Street and Number or Rura		Zip Code)
	12 h a 7 is tra			5 Millers Station 1		
Jre,	of Healt of Healt litem 2		comaton, c	ematory`or other place)	ate 20c. Location - City or	Town, State
Ĕ	Page ment ant: If ury o		1 Denation 5 □ Other (Specify)	it Grove Cem. 08/12	/2004 Reisterst	own, MD
Baltimore,	permit. Pages in Department of Huportant: If ite any injury or of once.		21. Signature of Fyneral Service Licensee 1900723		Eline Funeral Home , Hampstead, MD 21	
			23a. Part J. Enter the disease, or complications that caused the death. Do not experience the disease of complications that caused the death.			Approximate Interval Between
	Pnysician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	mara a		Onset and Death
	/Medical		resulting in death) Due o (or as a consequence of):	"YJC		-3-WEEKS
	Examiner		Sequentially list conditions, b. Andxia			3 weeks
	ted nsit	Examine	if any, leading to immediate cause. Either Underlying Cause (Disease or injury			
<u>,</u>	execu n and ial-tra	Exar	that initiated events resulting in death) Last c			
8760,	cate be executed physician and the burial-transit	dlcal	d			
9		Medi	IF FEMALE:			
Вох	leath certifi attending I I for use as	lan/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	Ectopic pregnancy	23d. Date of del Month	ivery Day Year
0.	The law requires that the death certifi ate has been signed by the attending of page 2 should be detached for use as	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	i ☐ Other (specify)		Day Tour
<u>α</u>	that the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
Records,	quires n sign ald be	Completed by	Complex Congenital Heart	Disease	1 ☐ Yes 2 No 3 ☐ Pr	obably 4 Unknown
S	law require as been sig 2 should b	plete			24a. Was an 24b. Were au	topsy findings available
R	The ia	mo			performed? death?	completion of cause of
Vital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death		
of \	shys this al dir	၉	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpat		ne 5 Residence 6 Other (Spec	cify)
	ffer ne	tlon	27. Manner of Death Statural 5 Pending (Month, Day Year) Accident investigation (2004)		28d. Describe how injury occurred	
Division	Attending ir death. ector: After by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,		28f. Location (Street and Number or Ru	ıral Route Number,
ă	s after	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, State)	
	To the Hospitel or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fun	edical (29a. Certifier Certifying Physician: To the best of my knowledge, de (Check only one) Check only and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the cause(s) and manner as ed at the time, date and place, and due	stated. to the cause(s)
	To the within To the comple	Mec	29b Signature and title of certified	29c. License number	29d. Date signed (Month	h, Day, Year)
	1/	2	Mohamod Gattoor, M.C.		83 8-8-0	4
0	1		30. Name and address of person who completed cause of death (Item 23a) (Typ		ON ON OID) [
	Sta	ite	31. Date filed (Month, Day, Xear) AUG 1 3 2004	1	C)/(U) -1CC	1
	Registr	ar	HUU I O ZUU4	sparks!		

			For State Registrar	tate of Ma	ryland / [Departme <i>Certifica</i>			nd Me		giene	Market St.	25511
_	Physic		1. Decedent's Name (First, Middle, Last) Erma VIPg/Maa	Bull					2	Date of Dea	Day	Year	3. Time of Death OO 20 M
	/Medi Examir		4a. Facility Name (If not institution, give stree Carroll Hospital Ce			4b. Ci	-	r Location of			4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M	7. Age	(In yrs. last bir	rthday) If Und Month	ler 1 Year s Days	If Under 2 Hours	Min. C	Date of Birth (Month, Day Oct 10,	, Year) 1909	Cou	place (State or Foreign ntry) YLand
	ryland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City Limits
7	r 28a-f s	Director	Maryland Carroll 10e. Street and Number			10f. 2	Zip Code	Hamp	stead		10g. Citizen of	What Cou	1 ☐ Yes 2] No ntry?
Sai	leath with ns 23a o	Funeral D	4022 Gill Avenue	Was Decedent Ev	ver in U.S.	13. Was Dec	cedent of H	2107		fy Yes or No-		JSA e - Ameri	can Indian,
4	ING 21215-0036 be filed within 72 hours after death with the Maryland that Hygiene. std other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	þ	1 Never Married 2 Married	Armed Forces? I □Yes 2☑ No If Yes, Give Year or Dates:			ecify Cuba 2€ No	n, Mexican, Specify:	, Puerto Rio	cán, etc.)	Specif	ck, White,	etc. hite
MECINIA	21215-0036 d within 72 hours aft giene. rr then "natural", or the Medical Eran'	Completed	15. Decedent's Educati (Specify only highest grade co	on <i>mpleted)</i> College (1-4or 5+		Decedent's Us (Give kind of life. DO NOT	vork done	during most	of working		16b. Kind of B		
-	e filed within all Hygiene.	Be Com	17. Father's Name (First, Middle, Last)		, <u> </u>	Home	maker		r's Name (F	First, Middle,	Owr Maiden Suman	n Horn	e
3	Maryland d 2 should be fill th and Mental H i? Is marked oft traumatic even	To B	William Wisner 19a. Informant's Name/Relationship (Type,	Print)	196	. Mailing Addre	ss (Street			ine Her	ndrix r, City or Town,	State. Zii	2 Code)
-	re, Maryla s 1 and 2 should f Health and Mer ltem 27 is marke other traumatic		Betty Wolfe, daught				ill A			ostead,	MD 210	074	
RA	Page nent o ant: if		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remi '4 ☐ Donation 5 ☐ Other (Specify)	2	St. I	ry, crematory o Paul's	r other place Cem.	(08/13,	/2004	Uppe	rco,	
M	Baltim permit. Pa Departmen important: any injury		21. Signature of Funeral Service Licensee	UCI	9723 UN	93	4 Sou		in St	, Hamps	uneral stead,		1074
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commediate Cause (Final disease or condition	ons that caused to ause on each line Rock		not enter the m		-		espiratory arr	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a	consequence	of):							
	8760, cate be executed chysician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	consequence	of):	-						
	Box 68 leath certificat attending phy	n/Medi		f yes, outcome of					-		23d. Da	te of delive	ery
1	that the deathed by the atte	hysicia	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		3 □Ectopic 5 □ Other					Mo	nth	Day Year
	rdS, P quires that n signed build be det	d by P	Part II. Other significant conditions contrib	uting to death but	not resulting in	n the underlying	j cause givi	en in Part I.					he cause of death?
	DIVISION Of VITAL RECONDS, P.O. BOX 68/60, i or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	Hypertens!	oy						24a. Was a autops perform	med? (death?	opsy findings available impletion of cause of
	f VItal F ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ital:			Othi	or.		1 ☐ Yes	ne)	Yes	
,	on of ding Phys h. After this funeral di	lon: To	27. Manner of Death 1 Natural 5 Pending	8a. Date of Injury (Month, Day		Itpatient 3 Time of njury	28c. Injun Worl	4 🗆 1401.	280		ence 6 Oth		ý)
	OIVISIO or Attendi infer death. Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injur building, etc.	y - At home, fa (Specify)			163 2 11		Location (SI City or Town	treet and Numb n, State)	er or Aura	al Route Number,
•	Hospita 4 hours Funeral ely fillec	Medical Ce	29a. Certifier 1 Certifying Physicia (Check only check on the check of the check only check on the check only check on the check on th	On the basis of e	examination an	e, death occurre	ed at the tim	ne, date and pinion, death	place, and	d due to the ca	ause(s) and ma ate and place,	nner as s	tated. o the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner state	9d.	2	9c. License	e number	•	2	9d. Date signer	(Month,	Day, Year)
	11	1	30. Name and address of person who comp	eted cause of dea	ath (Item 23a)	(Type, Print)	12	How	- 50, h.	000	(110)	miles	to-10
	21 0	ate	31. Date filed (Month, Day, Year)	32. Registrar		G &		11 Sign	1	R. YE		-61 -61	121157
	Regist	rar	AUG 1 3 2004	for men	- fo	1 plans	Sailer Lange	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Mary Jacqueline Benner R.S.M. August 10 2004 11:45 Α. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore The Villa Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F Director 60 01/05/1944 VA 576-44-1666 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28s-f show the M-cical Examiner oust be notified at 1 Yes 25 No Directo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 Bellona Ave. 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify: Specify: þ 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 Religious Sister Religious 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be inent of Health and Mental Int: If item 27 is marked o John Arthur Benner Mary Louise Monroe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sisters of Mercy 1300 E. Northern Parkway Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 08/13/2004 Woodlawn, MD 21. Signature of Funeral Service Ligonsee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, 736 Edmondson Ave. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician netastato Casinoma reary disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2PNo 2 2 No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Than foon, MD FAED D 57088 August, 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

Than Rom 201 57 Paul Plau, # >6 (Baltimen, m) 2/202 Thaw Ken 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

			For State	State of Maryland	/ Department of Health and I Certificate of Death		0001	OFFIO
			Registrar 1. Decedents Name (First, Midd	lle, Last)	Certificate of Death	Reg. 2. Date of Death		3. Time of Death
	Physicia /Medic	an	Traynor	V. Bowser		. 0	O 2004	1 28 A M
	Examin	er	4a. Facility Name (If not institution SAINT AGNE		4b. City, Town, or Location of Death	n	4c. County of Deeti	NA
	Funeral Director		5. Social Security Number 240-32-8004	6. Sex 1 M 2 SE 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You	9. Birth	nplece (State or Fireign untry)
_	yland		Usuel Residence of Decedent 10a. State 10b. Count	y 10c. City,	Town or Location			10d. Inside City Limits
	the Mar 28a-1 al	ector	10e. Street and Number	NA	1501+1more	10a	Citizen of What Co	1 ⊠Yes 2 □ No
	death with the Maryland ma 23a or 28a-f ahow	ai Dir	122 NAll	endale Street	21229		USA	
36	5 £ 5	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	If Vac Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 25 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
2-00	72 hour natural dical Ex	ted b	15. Decede		16a. Decedent's Usual Occupation (Give kind of work done during most of work		b. Kind of Business/	ndustry
21215-0036	within iene. than "	ompie	Elementary/Secondary (0.12)		HOUSEWIFE		Home	2)
	be filed ntal Hygi od other avent, L	Be	17. Father's Name (First, Middle	a, Last)	18. Mother's Nar	me (First, Middle, Ma	_	
Maryland	should and Men a marks umatic	ဥ	19a. Informant's Name/Relation	nship (Tyge, Print)	19b. Mailing Address (Street and Number of F	ural Route Number, C		(ip Code)
	1 and 2 Health a em 27 li		20a. Method of Disposition	Ser (Daughter)	8351 South Langler ce of Disposition (Name of	Ave# 20	Chicago Location - City	D. IL 606/ Fown, State
Baltimore,	Pages nent of I int: If its ury or o			1 3 Hemoval from State	en Nount Cremetory 8-	13-04 R	attimore	ams
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service	e Licensee	22. Name and Address of allity (8728 Liberty R)	Kanaan	otown, m	tral Service D 21133
			23a. Part1. Enter the di lea e, shock, or heart fail bre Li Immediate Cause (Final		Do not enter the mode of dying, such as cardia	or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Cerebello Due to (or as a conseque				Days
	Examiner	'n	Sequentially list conditions,	b. Brain Due to or as a conseque	Aneursym			Days
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	· uncont	rolled hypertens	sia.		Years
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9	artificate ing phy e as the	Medic	IF FEMALE:					
RAYN P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dear 9 Unknown	leath 3 Ectopic pregnancy		23d. Date of deli Month	very Day Year
S	quires that in signed by	ed by Ph	Part II. Other significant condi		ing in the underlying cause given in Part I.		cco use contribute to	the cause of death?
Bow SER	The law requirate has been sipage 2 should	ompiet				24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of 2000No
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Charles to the control of the contro	Other	ath (Check only one)	e Cother (See	-4.1
200	ding Phys h. After this funeral di	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	28a. Date of Injury	28b. Time of Injury Work?	dome 5 Residence 28d. Describe how		ony)
<u> </u>	or Attending Physicien: filer death. Director: After this certifics in by the funeral director.	Certification:	2 Accident inve	stigation	M 1 ☐ Yes 2 ☐ None, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,
NAME	To the Hospital or Attention Within 24 hours after death To the Funeral Director:	Medical Ce			ledge, death occurred at the time, date and plac on and/or investigation, in my opinion, death occ			
	To th within To th comp	Me	29b. Signature and title of certi	Lea	29c. License number		. Date signed (Monti	h, Dey, Year)
	019	/	30. Name and address of person	PHYSICIAN on who completed cause of death (Item	23a) (Type, Print)		ugust 10	- 2009
	7)		LAURA KHAN	MAGUE 900 Sc	23a) (Type, Print) buth CATON AVENUE	BAUTIMO	ire man	ossis anank
	St Regist	ate trar	31. Date filed (Month, Day, Ye AUG 1 3 2	2004 Figure Signature	e poussi			

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 04 August 2004 11:31a Mildred Veronica Boyd 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Harford Aberdeen 1936 Bennett Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2XF Yrs 64 06/28/1940 Maryland 217-36-2850 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No Harford Aberdeen 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1936 Bennett Road 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 Yes 20 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Virginia Abbott James Bryon Boyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1000 Schucks Rd., Bel Air, MD 21015 Frances Cianelli- Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 □Cremation 3 □Removal from State 08/07/04 Havre de Grace, MD Mt. Erin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, maure MD 21078 1 23 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co quence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No

Examiner attending physician The law requires that the signed by t d be detach Division of Vital Recórds. certificate Physician: director, this nours after death.

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filled in by the funeral di or Attending

Examiner Physician/Medical þ Completed Be Certification: To

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Baltimore, Maryland

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MD

9 Unknown 1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

Medical

State

4 ☐ Homicide

25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No 27. Manney of Death

investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

29b. Signature and title of certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GALVEZ

D-15994 UNION AVE HAVRE DE GRACE

29d. Date signed (Month, Day, Year)

5 LETICIA 31. Date filed (Month, Day, Year)

625 MD 32. Registrar's Signature

Registrar

within 24 hours To the Funeral

2

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Walter Bragg August 8, 2004 10:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) March 21,1916 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 88 Yrs. Director 234-14-9511 Ohio Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location orient: if item 27 is marked other than "natural, or items 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Directo Maryland Montgomery Silver Spring 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15107 Interlachen Dr. 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married I ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Specify: White Completed permit. Pages 1 and 2 should be filed within 72 it popartiment of Health and Mental Hygiene. Importent: if item 27 is marked other then "naturally or other traumatic." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Civil Servant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Bragg Alice Guntrup 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas W. Bragg / Son 1437 Hampton Hill Cir.; McLean, VA 22101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 \(\overline{\overline{\Omega}}\) Burial 2 □ Cremation 3 □ Removal from State August 10 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Gardens Rockville, MD 2004 21. Signature 22. Name and Address of Facility Rapp Funeral and Cremation Services M00382 933 Gist Ave.; Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia 2 years /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, any leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 months Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 X № To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl- one) Other: 4 Nursing Home 5 Residence 6 10ther (Specify) Hospice Hospital: ဥ 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 X Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No i Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours arre-29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) mon 0 0 0 nd address of person who completed cause of death (Item 23a) (Type, Print) Joyson Karakunnel M.D.; 6001 Muncaster Mill Rd.; Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG1 3 2004

DHMH 17 Rev 1/2001

BRAGG, to be

DEVIN BRANCH Unpend item # 23a, 27, 28a-1, per ME 6834, 8/27/04 TT State of Maryland / Department of Health and Mental Hygiene 04-5070 dap Amend item State Registrar #8, per Fh, G834, 8/27/04 TT Certificate of Death Reg. Nø. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Year JUWAN DEVIN BRANCH 4, 2004 AUGUST 9:15p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth8/20/1998 irthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 24 M 2 □ F Yrs 215.53.4105 **Director** MO Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location **show** 10d. Inside City Limits **Funeral Director** MD 1 Yes 2 No ANNE ARLINDEL GLEN BURNIE ?7 ie marked other then "neturel", or Items 23e or 28e-f treumetic event. It e Madical Examir er must be notiffe 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? BRIGHTON PLACE 876 21061 LLSA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT NIA IST GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROBERT S. BRANCH DONNA SYDNOR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a ROBERT S. BRANCH 876 BRIGHTON PLACE GIEN BURNIE, MD 21061 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' to ! 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ō tment tent: If injury o * 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE 08-10-04 MD CROWNSVILLE permit. Departn Importe any inju 21. Signifure of Funeral Service Liquisee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE
5151 BALTO. NATU PIKE BALTO. MD 21229 ow. 23a. Part1. Enfar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Arrest due to Anaphylactic Reaction /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Completed by Physiclan/Medlcal IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 □ No 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 【X ER/Outpatient 3 ☐ DOA 1 XYes 2 ☐ No Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) ieret Director: After th filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 8/4/04 8:24 p M death. 1 Yes 2 XNo subject ingested walnuts 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide 876 Brighton Place Glen Burnie, MD 21061 Residence within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 5, 2004 **AUGUST** oder Millag 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HEUDOREM, KIN

State Registrar AUG 1 3

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registre AMEND ITEM #5 per FH C834 8/26764 cate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day VERNAL BLACKWELL 2247 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND BALTIMORE at 4 NA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. So243 - 444 158 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2**⊠**F 14 Yrs. 20-1931 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4005 BATEMAN AVENUE 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♠No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) REGISTRA HOSPITAL 12TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GRIFFIS GEORGE MILDRED GRIFFIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 BATEMAN AVE. BALTO. MO WILLIAM BLACKWELL, JR. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 **⊠**Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST OWINGS MILLS, MD * 4 □ Donation 5 □ Other (Specify) 8-16-04 21. Signa re of Funeral Service Licented 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE och 5151 BAUTO. NATE PIKE, BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Sepsis disease or condition resulting in death) 2days Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hronic obstructive pulmonan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death. Check onl. one. Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 1npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

10a, State

Director

Funeral

Director

the

Item 27 is marked other than "netural", or Items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Itel any injury or other treumatic event, the Medical Examina-

Baltimore, Maryland 21215-0036

Examiner nding physician a use as the burial-Physician/Medicai use as þ Completed Be 2 funeral Certification: After

the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: A

Division of Vital Records, P.O. Box 6876

State Registrar

Medical

AUG 1 3 2004

6 Could not be

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

C. HUYNH

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause # death (Item 23a) (Type, Print) 22 SOUTH GREENE STREET, 32. Registrar's Signature

1 ☐ Yes 2 ☐ No

P17668

BATTIMONE, MD 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

08/07/2004

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DOS 04-05120 William Bruc∈

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iam	Bruce		1 - State of Mar State of Mar Registrar	yland / Department of Health and Mental Hygiene **Certificate of Death** **Reg. No. () () () 255						
	Physici		Decedent's Name (First, Middle, Last) William	Brı	ıce		2. Date of Deat Month	th Day Yea	3. Time of Death	
}	/Medic Examin		4a. Facility Name (If not institution, give street and number) Maryland General Hospital			or Location of De timore		4c. County of D		
	Funeral Director		5. Social Security Number 218–60–6389 6. Sex 1 1 2 1 1 2 1 1 1 2 1 1 1 1 2 1 1 1 1	(In yrs. last birthda) Yrs.	Months Days		8. Date of Birth (Month, Day, 12–9–4	Year)	Birthplace (State or Foreign Country) Md.	
	nyland how		10a. State 10b. County 1	10c. City, Town or I			· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits	
	he Ma	Director	Md. NA	Balti					1 X Yes 2 □ No	
	3a or 2	I Dir	501 Dolphin St. Apt. 1	408	10f. Zip Code 212	17	'	10g. Citizen of What Country? USA		
39	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, Ita Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Event Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		. Was Decedent of If Yes, specify Cu		(Specify Yes or No- erto Rican, etc.)	Black, W	merican Indian, hite, etc. Black	
Maryland 21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occu re kind of work don	e during most of	16b. Kind of Busine	ss/Industry		
121	filed within Hygiene. other then " ent, the Mes	ldmc	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade	life.	DO NOT use retir	· ·	Welde	er		
d 2	e filed al Hygic other vent, t	Be C	17. Father's Name (First, Middle, Last)		Labore		Name (First, Middle, M		<u></u>	
ylar	2 should be tand Mental I s marked o aumatic eve	ToE	David E. Bruce,			Doro		Swing		
Mar	d2sh thand t7lsm traum		19a. Informant's Name/Relationship (Type, Print) Myrna Bruce-Moore Daughto				, Glen Bur		a, Zip Code) 21061	
re,	is 1 and 2 of Health item 27 I	1 18	20a. Method of Disposition	20b. Place of Disc				20c. Location - City		
Baltimore,	Pages ment of h ant: If ite ury or of		1738 yrial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Mt. Zio		1	13-04	Lansdowr	e, Md.	
Balt	permit. Pages 1 a Department of Hea Important: If item eny injury or othe		21. Signature of Funeral Service Licensee	resp	March F.		Balti 1101 E.	imore, Md. North Av	. 21202 7e.	
П			23a. Part 1. Enter the disease, or complications that caused the spock, or heart failure. List only one cause on each line.	ne death. Do not e	nter the mode of dy	ring, such as card	liac or respiratory arre	est,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	consequence of):	Henry	Ly				
н	Examiner		/	3011304001100 017.		·				
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury	consequence of):						
_,	s be executed sician and burial-transit	Examiner	triat initiated events	consequence of):						
8760,	cate be ohysicial the buri	dicall	d							
.O. Box 68	ne death certifii the attending p hed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tire 9 ☐ Unknown	Fetal death 3	□Ectopic pregnan	су		23d. Date of a Month	delivery Day Year	
rds, P.	w requires that the bean signed by should be detact	ρ	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause g	iven in Part I.			to the cause of death? Probably 4 Unknown	
		Completed					24a. Was ar autops perform 1 Yes 2	ned? death	autopsy findings available o completion of cause of ? es 2 □ No	
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1X Yes 2 □ No Hospital: 1 X npatient	2 ER/Outpati	ent 3 DOA	ther	Death (Check only only only only only only only only		nacify)	
	ng Phy ter this neral c	n: To	27. Manner of Death 28a. Date of Injury		of 28c. Inj	the second second second		ow injury occurred	oecny)	
Division	I or Attendin after death. Director: Aft I in by the fur	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injun building, etc.	v - At home, farm, s	M 1[Yes 2 No	28f. Location (St. City or Town	reet and Number or n, State)	Rural Route Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical Ce	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of (Check only one) Madical Examiner: On the basis of and manner state	xamination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death o	ace, and due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)	
	To the within To the comple	Mec	29b. Signature and title of certifier			nse number		9d. Date signed (Mo		
	4		30. Name and address of person who completed cause of dear	ith (Item 23a) (Type	e, Print) 111]	Penn Str	eet, Balti	more, Mar	cyland 21201	
	Sta	- 7	31. Date filed (Month, Day, Year) 32. Registrar		, ,					
	Regist	rair	AUG 1 3 2004 Server	D A	months					

		•	For State Registrer	State of Ma	ryland /	-	tment of H		nd Men	tal Hygier		
	ō		1. Decedent's Name (First, Middle, Las							Date of Death	4004	3. Time of Death
	Physicia /Medic		David Edwar	d Bruc	e						Day Year Zooy	9.10 PM
>	Examin		4a. Facility Name (If not institution, give	street and number)	(L		tb. City, Town, or				c. County of De	ath
			BaltimoreVA				Balt	_			NA	
	Funeral		5. Social Security Number 6. S 219–28–4228	FM 2DF	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hours	Min. 8. C	Date of Birth Month, Day, Yea	(r)	inthplace (State or Foreign Country)
	Director	}	Usual Residence of Decedent	A	71					1-27-33	3	Md.
	yland		10a. State 10b. County		10c. City, Tov	wn or Loca	tion					10d. Inside City Limits
	e Mar	cto	Md. NA		В	altim	nore					1X Yes 2 No
	or 26	Director	10e, Street and Number	3 3-nd-	1 206		10f. Zip Code 2121	7		10g. (Citizen of What C USA	Country?
	4 within 72 hours after death with the Maryland jiene. r than "naturel", or tleme 23a or 28e-1 show It e Macileal Examiner must be notified a		1102 Druid Hill	12. Was Decedent E	. 1206	i	Is Decedent of Hi		2 (Specify	Voc or No	14. Race - Am	agrican Indian
_	iter di	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? XXYes 2 No. 11 Yes, Give		If Y	es, specify Cuba	n, Mexican, P	Puerto Rica	n, etc.)	Black, Wh	
9500-6121	elf, o	by	3 ☐ Widowed 4 ☑ Divorced	fr Yes, Give Year or Dates:		1	∃Yes 2XNo	Specify:			Specify:	Black
<u>ئ</u>	72 hc	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a	(Give kir	nt's Usual Occupa nd of work done of	furing most of	f working	16b.	Kind of Busines	s/Industry
7	withln ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. DC	NOT use retired aborer)		·	Varies	
א ס	filed v Hygie other t		12th grade 17. Father's Name (First, Middle, Last)			ПС	DOLEL	18. Mother's	Name (Fir	st, Middle, Maid		
a	e d a b y	To Be	David		Bruce,	Sr.			othy	ot, 17110-10, 171410	Swing	ler
2	5 ≥ € 6	F	19a. Informant's Name/Relationship (Type, Print)	19	b. Mailing	Address (Street a	and Number o	or Rural Ro	ute Number, City	or Town, State,	Zip Code)
Z Z	s 1 and 2 sh t Health and item 27 te m other treum		Valerie Bruce	Daughte	er	10248	B Hickor	y Ridg	e Rd.	, Columb	oia, Md.	21044
Baitimore,	0 0		20a. Method of Disposition 1 XBurial 2 Cremation 3	Pemoval from State	20b. Place o	of Dispositi ery, crema	ion (Name of tory or other plac	e)	Date	20c.	Location - City o	r Town, State
Ĕ	Pages ment of ent: If it ury or o		4 □ Donation 5 □ Other (Specify		Garris	son F	orest Ve	t. 8	3-13-0	4 0	wings Mi	lls, Md.
ă	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licer	1500			Name and Address	-	1.7		ore, Md.	
	70 = 4 0		23a. P Enter the disease, or com	I. Wall	yp		rch F.H.				orth Ave	
			23a. P Enter the disease, or com ho k, or heart failure. List only Imm d de Cause (Final	one cause on each line	э. `					piratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		dis-ast or condition resulting in death)	a Pulm. Due to (or as a	enar	3	Embol	ism				C
	Examiner			Sep 5		on):						Sixteen
	SHIP.	je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a		of):						Two
	sate be executed bhysicien and the burial-transit	Examine	that initiated events				nay					years
Ď,	e exe	EX	resulting in death) Last	Due to (or as a	consequence	of):						
8760		dicai		d								
× e	eeth certific attending p	/Me	IF FEMALE:	23c. If yes, outcome o	of pregnancy						23d. Date of de	livoru
ROX	atten	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetel deat		ctopic pregnancy other (specify)				Month	Day Year
o.	by the destached	Physician/Me	9 Unknown	9□ Unknown								
ď.	res that igned to be det	ру Р	Part II. Dther significant conditions of	ontributing to death but	t not resulting	in the unde	erlying cause give	en in Part I.		23e. Did tobacc	use contribute	to the cause of death?
ğ	w require been sig should b								_	1 🗆 Yes	2 □ No 3 🗗	robably 4 Unknown
Division of Vital Records,	The law requires that the deeth certific ate has been signed by the attending p page 2 should be detached for use as	Completed							_	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
~	sicien: The law certificate has b irector, page 2 s	Con								performed? 1 ☐ Yes 2 ☑ 1	death?	s 2□No
Vita V	Iclen: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		Death (Ch	eck only one)		
O	Phys this ral dir	To.	1 Yes 2 No 27. Manner of Death	1 Le Inpatien		utpatient Time of		4 🗀 1401 SII		5 Residence Describe how in	6 Other (Spa	ecity)
0	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injury Work	rat (? Yes 2 □ No		Describe flow in	ury occurred	
/S	Atten r deal sctor: y the	fica	3 Suicide 6 Could not b	e 28e. Place of Injur	ry - At home, f	arm, stree			28f. L			Rural Route Number,
á	s after	Certification:	4 Homicide	building, etc.	(Specify)				(City or Town, Sta	ite)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical ((Check only 2 Medical Exer	nysicien: To the best of niner: On the basis of	examination a	ge, death o	ccurred at the tim	ie, date and p	olace, and o	fue to the cause	(s) and manner a	is stated.
	the hin 2 the I	Med	one)	and manner stat	ed.		29c. License					
	5 × 5 %	-	29b. Signature and title of certifier	15	11.5	-			1.1.		ate signed (Mon	
•	, 111		30. Name and address of person who	completed cause of do	ath (Item 23a)	(Type Pr	int)					8,2004
	4+1		Christian Tur			NO.	th Gree	ne st	. B.	altimo	UW 12	21204
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1	,					
	Registi	- 4	AUG 1 3 20	104 Bene	va	G	fore	1				
DH	MH 17 Rev 1/2	001		/	,		*					

ORIGINAL

	State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Certificate of Death Reg. No. 0 1 25520
Physician /Medical	1. Decedent's Name (First, Middle, Last) Renneth L. Becker 2. Date of Death Anoth Day Year 4.10 AM
Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Towson 4c. County of Death Towson
Funeral Director	5. Social Security Number 215 i4 5 i 84 1 1 1 M 2 F 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 24 Hrs. Months Days Hours Min. Oct 2 I 1920 9. Birthplace (State or Foreign Country) 1 Min. Oct 2 I 1920 Pennsylvania
h the Maryland r 28e-f show crotified at	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
th with the Mar 23a or 28e-f si ust be notified	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States
er dez	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes, Specify: 17. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)
Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Markel Hygiens, or Importent: If item 27 is marked other than "natural"; or any injury or other treumatic event, ir e Madical Exami DDCR. To Be Completed by F	
Baltimore, Maryland 21215 Baltimore, Maryland 21215 permit. Pages 1 and 2 should be filed within 72 Department of Health and Montal Hygiens, Importent: If item 27 is marked other than "n any injury or other treumatic event, Ir.e Mod once. To Be Compie!	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Maryla Maryla dd 2 should b ith and Ment 27 Is marked r treumatic	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) K. Virginia Becker / Spouse 3138 Cornwall Rd. Dundalk, MP. 21222
timore, I	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Avg. 13 2004 Baltimore, Maryland
Baltir Baltir Permit. F Departme Importen any Injury ang Injury	21. Signifure of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dyndalk, P.A. 7110 Sullers Pt. Rd. Dyndalk, MD. 21222
Physician /Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
8760, cafe be elecuted by social and the burial-transit direction and direction are directions.	
LC US. Box 6 death certiff e attending I d for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown IF FEMALE: 23c. If yes, outcome of pregnancy 1 23d. Date of delivery 2 23d. Date of delivery 3 23d. Date of delivery 4 23d. Date of delivery 4 23d. Date of delivery 5 23d. Date of delivery 4 23d. Date of delivery 5 23d. Date of delivery 5 23d. Date of delivery 5 23d. Date of delivery 6 23d. Date of delivery 7 23d. Date of delivery 8 23d. Date of delivery 9 23d. Date
S, S, estil	256. Did tobacco as contribute to the cause of usatir.
Of Vital Records, P.O Physician: The law requires that the rithis certificate has been signed by the rail director, page 2 should be detached. To Be Completed by Phys.	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 1 Yes 2 No
- 5 9 9 E	25. Was case referred to medical examiner? 1
Division of Divisi	2 Accident investigation 3 Suicide 4 Homicide Accident investigation M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
MENNETH Divisit To the Hospital or Attent within 24 hours atter death within 15 hours atter death completely filled in by the Medical Certifical	29a. Certifier (Check only one) Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To the within common NA	
12	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARON Charles, ND 6601 N Charled ST BARRINGE NO ZIZCY 21. Det flot West De Version of Desired Stranger Constraints 22. Det flot West De Version of Desired Stranger Constraints 23. Det flot West De Version of Desired Stranger Constraints 24. Det flot West De Version of Desired Stranger Constraints 25. Det flot West De Version of Desired Stranger Constraints 26. Desired Stranger Constraints 27. Desired Stranger Constraints 28. Desired Stranger Constraints 29. Desired Stranger Constraints 20. Desired Stranger Constraints 29. Desired Stranger Constraints
State Registrar	31. Date filed (Month, Day, Year) AUG 1 3 2004 32. Registrar's Signature

CPM 04 - 05044Amend Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene VALERIE BLOUNT 1 - For State Registrar item#23a,PII,27 per me,G834,8476,646,646 Unpend 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 04, /Medical August 2004 7:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 7. Age (In fyrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 2 9-76-4062 Usual Residence of Decedent Days Hours 1 🗆 M Yrs. Director filed within 72 hours after death with the Maryland 10a 10b. County 10c. City, Town or Lo 10d. Inside City Limits or 28a-f show iem 27 is marked other than "natural", or items 23e or 28a-f shot other traumatic event, I're Mudical Examiner must be notified at moRE Director Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 1 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Oo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 14. Race -1 Yes 2 If Yes, Give Year or Dates: Married 1 Never Married Baltimore, Maryland 21215-0036 1 Yes 21/10 Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO AIQT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mentat Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ISABIET 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NO W 198 formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MG U1502 3800 Pleasant M+. Calte. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Fremation 3 ☐ R
4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State injury or permit. Page Department of Important: If any injury or QQGE. etro Wematory 21. Signature of Funeral Service 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as careful shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) ned by the a nknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? Narcotic use 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an this certificate has autopsy performed? Ves **⊘**es 2 No 2 🗆 No 25. Was case referred to medical examiner?

12 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Injury 1 Yes 2 No investigation

To the Hospitel or Attending Physician: filled in by the funeral director, after death, Director: After t

24b. Were autopsy findings available prior to completion of cause of death?

2 Accident

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

3 🗌 Suicide

29a. Certifier (Check only one)

> 29c. License number O.C.M.E.

29d, Date signed (Month, Dav. Year)

August 05, 2004

State Registrar 30. Name any a dres of person to complete cause of death (em 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month

32. Registrar's Signature

, DR. MARYG. RIPPLE FOR

within 24 hours a To the Funerel I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>004</u> Month Year **Physician** August 9, 13:55 Junior Bratton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1.X1M 2□ F Virginia Director 219-30-2560 70 Jan. 14, 1934 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f ehow item 27 is marked other than "natural", or items 23a or 28a-f ebov other traumatic event, the Medical Exercities must be notified at 1 Yes 2 No Maryland Harford Bel Air Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1829 Churchville Road 21015 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ages 1 and 2 should be filed within 72 hours after in of Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sand and Stone Quarry Material Bagger 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Stella Smith James Bratton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Joyce Hooker - Sister 2817 Laurel Bush Road, Abingdon, Maryland 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

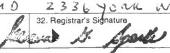
4 ☐ Donation 5 ☐ Other (Specify) permit. Pag Depertment Important: I any injury o 8/11/2004 Towson, Maryland Hilltop Serv. Corp. 21. Signative of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TO CHEST Pnysician SHOT WOUND resulting in death) /Medical Due to (or as a consequence of): Examiner SELP INFLICTED if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy ٥ Month Day Year 5 Other (specify) ☐ Yes 2 ☐ No detached Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, be CHRONICOBSENDETIVE PULMENAY 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 △ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2□ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ♠No death. AU9 9 2004 13=00 SELF IN ALICIED 2 Accident 24 hours after deat • Funeral Director: 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours aft To the Funeral Di completely filled ir 829 CHIRCHOILLAD BERMIRME 1400E Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Aug ust 9 121809 aush DM6 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) AUG 1 3 2004

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1, MONIUM 40 21543.

State of Maryland / Department of Health and Mental Hygiene ~ 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month sharles 2004 5:23fm /Medical ugus 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Hospital Center Northwest Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2 □ F 217-09-9630 Director Yrs July 30,1917 W. Virginia Usual Residence of Decedent deeth with the Maryland 10h County Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow ury or other traumatic event, the Medical Eventral mast be reditied at 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Randallstown 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9702 Liberty Road 21133 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No 3 ₩idowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry City Wide Management Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Domestic Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Raymond Carter Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Jefferson/Daughter 9702 Liberty Road Randallstown, Md 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 8/12704 permit. Pages Department of Important: If it any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State King Memorial Park Randallstown, Md `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Mensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute respiratory disease or condition resulting in death) tailure >6 hours /Medical Due to (or as a consequence of): Examiner edema ulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit failure and Chronic hear Congestive that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 pulmonary disease Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the a 9 Unknown 9 Unknown signed by t Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à marasmus 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No diabetes performe rmed? IVOC IL 1 Yes Hospitei or Attending Physician: 25. a case referred to medical 26. Place of Death Check onl one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 (DNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bostor Center Randallstown Vorthwest 31. Date filed (Month State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 240 BA.M KWAN 8 4006 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) NuRsinb Silver 12420076H H.71 orina longGomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **36** M 2□ F Months Days Hours Min 70 Yrs. 3880-12-816 SOUTH KORSP Usuel Residence of Decedent 10b Counts 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No MARY) ACC BALLIGORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? APT D.S.A M WIS SIGIB 1255 /6 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 No Specify: Specify: 3€ Widowed 4 Divorcad KORSAC 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 127 RC 2011810 lectrica iAn 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN OUKUPWU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRK 20b. Place of Disposition (Neme of BALLIMORE 70076 S00K JEFFA 160AD MARYLAND 20a. Method of Disposition 20c. Location - City or Town, State Date 200. Name and Address of Facility AUG. 10 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FOREST HILL CLORYLAND 400h 21. Signature of Funeral Service License FUNZRALANDERMATION NAT STER 2325 YORKROGO 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) FIBROSIS 4 GARS ULMONARY Due to (or es a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 201 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of

Physician/Medical Examine the bunal-transit or Attending Physician: The law requires that the death certificate be exect attending physicien for use es the burial Division of Vital Records, P.O. Box 68760 ed by the a signed b 2 is certificate has been si director, pege 2 should Completed Be Certification: To this After thi funerel within 24 hours after deeth.

To the Funeral Director: Af
completaly filled in by the fu

Physician

/Medical

Examiner

10a State

Director

by Funeral

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if Health end Mental Hygiene. Item 27 is marked other than "natural", or itams 23s or 28s-f show other traumstic event, the Madical Examiner must be notified at

Depertment of Health e Important: if Item 27 Is any Injury or other trait page.

Physician /Medical

Examiner

with the Maryland

Pages 1 and 2 should be filed within 72 hours after deeth

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TS Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature end title of cartifier

5 Pending

investigation 6 Could not be determined

Naturel

2 Accident

4 \ Homicide

3 Suicide

29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Year)

D08944

AUGUST 10 800L

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3720 FARAGUT M.D MARTINC. SHANGEL

KENSINGTON MD -208

State Registrar

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31. Dete filed (Month, Day, Year)

32. Registrar's Signeture Conte 2004

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			1 - For State Registrar	State of M	larylan	•			ealth a	ind M		Reg. No. 0 ()	dela control	255	25
	Physici		1. Decedent's Name (First, Middle, La. Faye Eleanor Chr								2. Date of Dea Month August	_	Year	3. Time : 3:10	of Death a M
>	/Medio Examir		4a. Fecility Name (If not institution, given Ivy Hall Assiste)		Mic	dd1e	River	c			timo		
	Funeral Director		21, 22 2,00		ge (In yrs. 83	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da Nov 2	year 1920	9. Birthp Cour I o	olace (State otry) Wa	or Foreign
	Aaryland F ehow	or	Usual Residence of Decedent 10a. State 10b. County Md. Harf	ord	10c. Cit	ty, Town or Lo	ocation Air			·			1	l0d. Inside (City Limits
	or 28a-	Director	10e. Street and Number	014				Code				10g. Citizen of W	hat Cour	ntry?	
920	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow disal Exercinat be multified at	by Funeral	1221 Marston Dri 11. Marital Status 1 □ Never Married 2 □ Married 3 ☎ Widowed 4 □ Divorced	12. Was Decedent Amed Forces 1 Yes 2 If Yes, Give	? INo		Was Dece If Yes, spe			gin? (Spe , Puerto i	cify Yes or No Rican, etc.)	United 14. Race Black Specify:	- Americ , White,	can Indian,	
21215-0036	I within 72 ho liene. r than "natur Ine Medical.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or	5+)		dent's Usu kind of wo DO NOT u	ork done d ise retired	during most)	of workii	ng	16b. Kind of Bus			ation
	be filed stal Hyg ad other event,	To Be Co	12 years 17. Father's Name (First, Middle, Last, Frederick J. Osw			1					(First, Middle,	Maiden Sumame)		
Maryland	end end sm	F	19a. Informant's Name/Relationship (Type, Print)			-		and Numbe	r or Rura	l Route Numbe	er, City or Town, S		Code)	
	s 1 and 2 f Health item 27 i		Lana E. Jones/da		20b. F	1221 Place of Disponentery, crei	The state of the s				ate Alr,	Md. 210 20c. Location - 0		own, State	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	y)	9	Air M	lem. (Gdns.	. 8		2004	Bel Air	, Md	•	
Ba	permit. Par Department Importent: eny injury		21. Sin turo. Funeral Service Licer	A PA			Schir	nunek	o Dhai	eral	ad Da	f Bel Ai 1 Air, M		nc. 1014	
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3760,	ate be executed hysician and he burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infriated events resulting in death) Last	Due to (or a Due to (or a	s a conseq	y A	RTE,	RY	D	152	ASE.				^b h.,
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1□Live birth 4□Pregnant a 9□ Unknown	2 Feta	uldeath 3[□Ectopic p □ Other (s)					23d. Date Mon		ery Day	Year
<u>α</u>	quires that n signed b uld be deta	b	Part II. Other significant conditions of	contributing to death	but not res	sulting in the u	inderlying (cause give	en in Part I.			obacco use contri res 2 🗆 No	bute to th		death? Junknown
Vital Records,	The law require ate has been six page 2 should t	Completed										rmed? pr	ere auto ior to co ath? Yes	psy finding mpletion of	s available cause of
Vita	sician: certific rector.	o Be (25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpat	aC	ER/Outpatier	nt 3 D	Othe	25		(Check only o	ne) dence 6 □Othe	- /Canail		
n of	ding Phys h. After this funeral di	<u> </u>	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	ury	28b. Time o	ıf :	28c. Injun	at	/ 1		now injury occurre		y/	
Division	Atten r deat ector: by the	Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Ir	njury - At h etc. <i>(Speci</i> i	ome, farm, str	M reet, factor		Yes 2 P		28f. Location (\$ City or Tox	Street and Numbe vn, State)	r or Rura	al Route Nu	mber,
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	To the within 2 To the complet	Me	29b. Signature and title of certifier				29	c. License	e number			29d. Date signed	(Month,	Day, Year)	
	7-1		30. Name and address of person who	completed cause of	LKG	n 23a) (Tyne	Print)	D 2	7/8	8		8/11/09	/		
/	2		Swinder K	Julla	2/4	10 rke	ot	1/4	e_	Die	75/1014	· Mn	21	222	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AIIG 1 3 2004	32. Regis	trar's Signa	ature									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Jennie Therese Cimino 12:30P 2004 10. August /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9514 Perry Hall Blvd., 204 Baltimore Baltimore Apt. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 18, 1928 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 👿 F Maryland 75 215-30-3474 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "netural; or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 u.s.A. 9514 Perry Hall Blvd., Apt. 204 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: White þ If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Troubleshooter Clothing Co. 10th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Cimino Salvatrice Brocato Salvatore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Hampton Road, Linthicum, MD 21090 Mrs. Mary Mandley (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/2004 Baltimore, Maryland Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Zmonth, **Physician** CRINCIS disease or condition resulting in death) /Medical Due to (or as a construence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 3 Probably 4 🗀 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No this certificate has 21 No 1 Yes 1 🗌 Yes 25. Was case referred to medical examiner?
1 □ Yes 2 □ Vo Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) Certification: To 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIGIN NU

Registrar DHMH 17 Rev 1/2001

State

31. Date filed_(Month, Day, Year)

AUG 1 3 2004

			1 - State of Maryland / Department Certification	nt of Health and M te of Death	lental Hygie	et a de	2007
	Physici /Medi		Decedent's Name (First, Middle, Last) BEATRICE HOPE CASE:	Y	2. Date of Death	Day Year	3. Time of Death 4 6:35 A ^M
>	Examir		Chesapeake Hospice House Lir	Town, or Location of Death		4c. County of Death Anne Ar	1
l	Funeral Director		5. Social Security Number 273 20 6045 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M Months 7. Age (In yrs. last birthday) 1 M Months	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye 12/13/1	9. Birth Cot 919 Ter	place (State or Foreign intry) INESSEE
	e Maryland 8e-f show diffed at	Director	MD Anne Arundel Pasadena				10d. Inside City Limits 1 ☐ Yes 2 No
	ath with th		10e. Street and Number 7718 Vena Court	21122		Citizen of What Cou	intry?
980	within 72 hours after death with the Maryland one. then "neturel" or Items 23e or 28e-f show he Medical Examanch was be routilled at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes, Spe 1 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Spe 1 Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Spe 1 Yes	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	
Maryland 21215-0036	·	Completed	College (1-4or 5+)	al Occupation ork done during most of workir se retired) Operator	ng	Kind of Business/Ir	,
yland ;	be file ntal Hyg ed othe event,	To Be C	17. Father's Name (First, Middle, Last) Eldon Casey	18. Mother's Name Rosa	(First, Middle, Maid Siler	len Sumame)	
	1 and 2 Health ar sm 27 is ther treu		Carolyn Scalio/daughter 7718 Ve	ena Ct. Pasa	adena, M		2
Baltimore,	permit. Pages Department of I Important: If its eny injury or o		'4 □ Donation 5 □ Other (Specify) Bayview Crem 21. Signature of Funeral Service Licensee 22. Name an	natory 8/11	/04 Ba J.Gonce	ltimore, Funeral	, MD
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Box 68760,	death certificate be executed a attending physician and d for use as the burial-transit	ician/Medical Examiner	Due to (or as a consequence of):			23d. Date of delive	ery Day Year
s, P.O.	res that the death signed by the atter be detached for a	by Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying ca		23e. Did tobacco	o use contribute to th	ne cause of death?
	ysicien: The law requires that the death certific is certificate has been signed by the attending idirector, page 2 should be detached for use as	e Completed by Physician/Me	Brandy tackys yadame - Pace		1 Yes 24a. Was an autopsy performed? 1 Yes 2	24b. Were auto prior to cor death?	psy findings available appletion of cause of
Ö	ling Ph	ertification: To Be	1 Matural 5 Pending (Month, Day Year) Injury 2 □ Accident investigation M			6 ☐Other (Specif))
	하셨습니	O	3 Suicide 4 Homicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify) 29a. Certifier 1 □ Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place, an	City or Town, Sta	·	
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical	one) and manner stated.	in my opinion, death occurred	d at the time, date ar	s) and manner as stand place, and due to ate signed (Month, L	the cause(s)
,	Ox		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	417744	d	11/00	
4	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 3 2004 Server & Spark	ruce, and	2106	1 SAC	18 A. SCEKEMA

			1- State Amend Item 5	State of Maryland per FH, G834, 8	/ Depa	rtment of	Health and PDeath	Mental Hy	/giene Reg. No	e 2004	255	. 20
100	Discorded		1. Decedent's Name (First, Middle, Last,					2. Date of D Month		- 00 0 A	3. Time of	Death
	Physici /Medic		Paula	Castro				August	10	•	6:46	P M
3	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	, or Location of Dea	th	40	. County of Dea	ith	
	0		Holy Cross Hospita				r Spring		Mo	ntgomer	У	
	Funeral		5. Social Security Number 6. Security Number	14 2ME		If Under 1 Year Months Day		. (Month, D			thplece (State o	or Foreign
C	Director		N/A UNKNOWN	73	Yrs.			June 1	4,19	31 E1	Salvado	r
and	* =		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside Ci	ity Limits
Mary	d a	ŏ	Maryland Montagnam								1 🗆 Yes	2]X] No
the	28a-	Director	Maryland Montgomer 10e. Street and Number	у 511	ver S	10f. Zip Code	•		10a Ci	tizen of What C	ountry?	
with	a di			#100		,						
leath	ns 23	Funerai	8851 Garland Ave.	12. Was Decedent Ever in U.S.	13.1	20901 Was Decedent o	f Hispanic Origin? (Specify Yes or N		alvador		
fter	5 3	F	1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	'	f Yes, specify Ci	uban, Mexican, Pue	rto Rican, etc.)		Black, Whi		
US a	9	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A. Year or Dates:		1∭ Yes 2□ N	lo Specify: Sa	lvadoria	.n	Specify: Wh	ite	
Z1Z13-UU36 d within 72 hours after death with the Maryland	ical	Completed	15. Decedent's Edu			dent's Usual Occ		net on a	16b. K	ind of Business	/Industry	
within 7	. u	pie	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	ne during most of wo ired)	nking				
N P	er th	0	0		House	Wife			Ow	n Home		
be filed	d oth	Be (17. Father's Name (First, Middle, Last)	Unk			18. Mother's Na	me (First, Middle	e, Maider	Sumame)	Unk	
and t	Ment arke attc a	2										
Maryland of 2 should be file	Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural; or items 23a or 28a-f ahow appringury or other traumatic avant, this Maclosi Exposite trais the notified at once.	10	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	ng Address (Stre	et and Number or A	lural Route Numi	er. City	or Town, State, .	Zip Code)	
	n 27		Jose M. Rodriquez/				Ave. #10		r Sp	ring, M	D 20901	
es 1	f ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	netery, cren	sition (Name of natory or other p	lace)	Date	,	ocation - City or		
Pages	ant: I ant: I ury o		*4 □ Donation 5 □ Other (Specify)	Cemet	tery	of Pasac	quina		La	unton,	El Sal	vador
Baltimore,	Department Important: I any injury o		21. Signature of Funeral Service Licens	ee 1 1.7		. Name and Add						
n &	2 = 9		Louin a	Shorenyngs	6/ 9	app Fune 33 Gist	eral And (rematio zer Spri	n Se	rvices MD 2091	0	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death.	Do not ent	er the mode of d	ying, such as cardia	c or respiratory	arrest,		Approximate Interval Bety	
Ph	ysician		Immediate Cause (Final disease or condition	Sepsis							Onset and D	
	Medical		resulting in death)	Due to (or as a conseque	nce of):						Days	
Ex	aminer	i		Pneumonia								
N 14		ner	Sequentially list conditions, transp. leading to immediate cause. Enter Underlying	Due to (or as a conseque	nea of):							
60, be executed	physician and s the burial-transit	Examiner	that initiated events	3.								
Č Č	an an irial-t	EX	resulting in death) Last	Due to (or as a conseque	nce of):							
9	ysici ne bu	Ical		d								
P.O. BOX 68 that the death certifica	as th	Jed	IC COLLEGE				72.0		-			
BOX eath cert	attending pl	Physician/Med	230. Was decedent pregnant	23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal de		lEctopic pregnar	ncv			23d. Date of del		
deal G	ed to	sicia	in the past 12 months? 1 ☐ Yes 2 🏋 No	4☐Pregnant at time of deal		Other (specify)				Month	Day Y	/ear
F.C.	ed by the a	hy	9 Unknown	3CJ OTIKITO WIT								
S, a	igned be de	by F	Part II. Other significant conditions con	ntributing to death but not resulti	ng in the ur	nderlying cause	given in Part I.	23e. Did	tobacco i	ise contribute to	the cause of de	eath?
VITAL RECORDS, stcien: The law requires t	should I				-			1 🗆	Yes 2	□No 3□Pr	obabiy 4 XIU	inknown
Hecords, The law requires	2 sh	ompieted						24a. Was		24b. Were au	topsy findings a	available
r e	page 2	E							ormed?	death?		IUSO OI
	certificate rector, pag	e C	25. Was case referred to medical				26. Place of De	ath (Check only		1	-X-110	
OT VITA Physician:	is cel	To B	examiner? 1 ☐ Yes 2 X No	łospital: 1 X Inpatient 2 ☐ EF	∛Outpatien	t 3 DOA	han.	Home 5 ☐ Res		6 ☐Other (Spe	cify)	
	ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	3b. Time of Injury			28d. Describe				
/ISION Attending	ath. r: At	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(1001111, 04) 1041)	,ury		☐Yes 2☐No					
VIS	acto acto by th	ific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	et, factory, offic	е	28f. Location (City or To			ıral Route Numb	ber,
2 🖁	s afte	Certification;	T I I I I I I I I I I I I I I I I I I I	building, etc. (opecity)				Ony or 10	WII, State	/		
Hospitel	hour unera ly fille		29a. Certifier 1 X Certifying Phy-	sician: To the best of my knowle	edge, death	occurred at the	time, date and plac	e, and due to the	cause(s)	and manner as	stated.	
the H	n 24 he Fi	edicai	one)	ner: On the basis of examination and manner stated.	n and/or inv	estigation, in my	opinion, death occ	urred at the time,	date and	I place, and due	to the cause(s)	
To	within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	ž	29b. Signature and title of certifie	10.0		29c. Lice	nse number			e signed (Monti		
•				unymo		25.	4347		08-	-11-2	00 4	
	4		30. Name and address of person who co									
)		Neeraj Chopra, N	1.D.; 1500 Fore	st Gl	en Rd.,	Silver S	pring. M	ld. 2	0910		
	Sto	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur								
100	310		AUG 1 3 2004			1						

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State of Ma	ryland		rtment of Heal		-	giene	0.01	25520
		Physici	an	Decedent's Name (First, Middle, Las	ή) ΛΛ.	0	ame	hell		2. Date of De	ath Day	7 200	3. Time of Death
	>	/Medic Examin		4a. Fecility Name (If not institution, give	141-0-			4b. City, Town, or Local		lugus	4c.	County of Dea	7 01.12
		Funeral Director			2 T (0.1 3x 7. Age □ M 202 F	(In yrs. last	birthday) _		nder 24 Hrs. urs Min.	B. Date of Bir (Month, Da	th iy, Year)	9. Bir	thplace (State or Foreign
			,	Usual Residence of Decedent 10a. State 10b. County			own or Loc	ation		reo. a	191	7 980	10d. Inside City Limits
		the Mary 28a-f sh	Director	MD NA 10e. Street and Number		Balt	imore	10f. Zip Code			10g Citi	zen of What C	10 Yes 2 □ No
		sath with	eral Di	4203 Flower	ton RD.	es in II C	40.14	21229	0::::0/0		451	7	
	900	ours after death with the Marylar rel', or Items 23a or 28a-f show Ex. oliver over be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			as Decedent of Hispani Yes, specify Cuban, Me Yes 2 No Spe	c Origin? (Spec. xican, Puerto Ri ecify:	ity Yes or No ican, etc.)		14. Race - Ami Black, Whi Specify:	
	Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "naturel", or items 23s or 28s-1 show reumatic event, If a Modical Experient real be inclified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)			(Give k life. D	ont's Usual Occupation ind of work done during ONDT use retired)	most of working	,	Hon	nd of Business	/Industry
	land 2	2 should be filed and Mental Hyg Is marked other eumatic event, I	To Be C	17. Father's Name (First, Middle, Last)	SR.		20111	18. N	nma	First, Middle,			
	Mary	1 and 2 short Health and N tem 27 is ma		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailing	Address (Street and No	ımber or Rural i	Batto.	er, City or	Town, State,	Λ
	more,	of of		20a. Method of Disposition 1	Removal from State	20b. Place come	e of Dispos etery, crema	ition (Name of atory or other place)	8-16-	te		cation - City or	
	Balti	permit. Pag Department Importent: any injury o		21. Signature of funeral Service Ucen	596	MUITI	22.	Name and Address of F	acility				21229 Beltomb
				23a. Part. Into the disease, or composition of the	olications that caused the cause on each line	ne death. [Do not enter		h as cardiac or	respiratory a	rrest,	TOTAL	Approximate Interval Between Onset and Death
		Physician /Medical Examiner		Immediate Cause (Final disease of condition resulting in death)	a. Hthros	consequen	<u>つれ</u> (ce of):	Varano	H DI	sease			Years
		bed .	niner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	contection	na of)r						
CX	1760,	cate be executed oblysician and the burial-transit	icai Examiner	that initiated events resulting in death) Last	cDue to (or as a d	consequen	ce of):						
	P.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	☐ Fetal de	ath 3 □E	ctopic pregnancy Other (specify)			2	3d. Date of de Month	ivery Day Year
	Records, P	equires that en signed b ould be deta		Part II. Other significant conditions of Dibbetes Me	ontributing to death but	not resultin	g in the und	lerlying cause given in P	art I.			se contribute to	the cause of death?
	II Reco	The law or cate has be page 2 sho	Completed by							24a. Was autop perfo 1 Yes		24b. Were as prior to death?	topsy findings available completion of cause of No
=	f Vita	nyeicien: nis certific	To Be	25. Was case referred to medical axaminer?	Hospital: 1 ☐ Inpatient	2 ERV	Outpatient	04	Place of Death (Other (Spe	cify)
qd.	Division of Vital	ath. r: After the funeral		27. Nanner of Death Natural 5 Pending 2 Accident investigation		Year) 281	b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	28	d. Describe h			
ampbe	Divis	s after de s after de al Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home (Specify)	, farm, stree	et, factory, office	28	f. Location (S City or Tow	Street and vn, State)	Number or Ru	ral Route Number,
0		To the Hospitel or Attending Physicien: The law within 24 bours after death. To the Funerel Director After this certificate has completely filled in by the funeral director, page 2.	edical (29a. Certifier Check only one) Certifying Physical Exam	ysician: To the best of iner: On the basis of e and manner state	xamination	dge, death of and/or inve	occurred at the time, date stigation, in my opinion,	e and place, and death occurred	d due to the at the time.	cause(s) a	and manner as place, and due	stated. to the cause(s)
	•	To the within to the comp	Me	29b. Signature and title of certifier	1 orion	NN		D587	(C)		A	signed (Mont	7, Day, Year)
		5		30. Name and address of person who of Suran Esport	completed cause of dea	th (Item 23	Ave	enue Batt	More				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar'	s Signature	4	Sparker	4	11 (41))		
	DH	MH 17 Rev 1/20		AUG 1 3 20	104		1	popular					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 12, Elise Merritt Callaghan 2004 <u>10:</u>30P ^M August /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 18617 Walker's Choice Rd. Apt. 1 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Director 577-32-9823 June 17, 1927 Washington D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Exeminer must be notified at 1 Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18617 Walker's Choice Road Apt. 1 23a 20886 USA or Items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after ☐Yes 2XNo 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🂢 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Executive Secretary Research Organization marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fi. of Health and Mental H fitem 27 is marked ott Be Robert Gwathmey Merritt 2 Helen Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Thoren Bond/daughter Amcongen Amsterdam, PSC 71 Box 60 APO AE 09715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 13. 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Importent: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 2004 W. Arundel Crematory Odenton, Maryland 21. Signature of Funeral Bervice-License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Deve Mol25/ Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a Metastatic Breast Cancer Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physiclan/Medlcai 6876 Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) P.O. signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 8 1 ☐ Yes 2 No Completed 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 ☑ No Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 1 ☐ Yes 2 X No this 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 ₩Natural 2 Accident 5 Pending death. investigation M 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Dire 4 | Homicide Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D42452 August 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal M.D. 18111 Prince Phillip Drive #327 Olney, MD 20832

State Registrar

DHMH 17 Rev 1/2001

AUG 1 3 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sports

			1 - For State Registrar	State c	f Ma	ryland / Depa			eaith a Death	ind Me		gien Reg. N	ani.		25531
	Physici	an	1. Decedent's Name <i>(First, Middle, L</i> a Betty	st)		Chism				1	2. Date of De Month	Da	ay Ye	ar	3. Time of Death
Ž	/Medi Examir		4a. Facility Name (If not institution, giverally 3206 Spartan Dr.		mber)	OIIISM	4b. City,		Location of	f Death	August		.2 200 County of to Monts	Death	1:00 A ^M
	Funeral		Social Security Number 6. S	ex	7. Age	(In yrs. last birthday)	If Under		if Under 2 Hours	24 Hrs. 8	B. Date of Bird (Month, Da	th V Year			ace (State or Foreign ry)
	Director		Usual Residence of Decedent	□ M 2 🕅 F	80	Yrs.		Days	Hours				924 Pe	enns	ylvania
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic event, the Medical Exertires must be notified at	ctor	Maryland Montgo	mery		10c. City, Town or Lo Olney	cation							10	d. Inside City Limits 1 ☐ Yes 2 No
	with the	Director	10e. Street and Number				10f. Zip	Code				10g. Ci	itizen of Wha	t Count	ry?
	Jeath The 23	Funeral	3206 Spartan Dr.	12. Was Dece	edent Ev	ver in U.S. 13. V	208 Was Deced		spanic Origi	in? (Speci	ify Yes or No		ted St		
36	irs after o	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🌠 Divorced	Armed For 1 Tyes If Yes, Given Year or D	2 ∑ No ∕e	-	fYes, spec I □ Yes	offy Cubar	Specify:	Puerto Ri	can, etc.)		Black, V	Vhite, e	tc.
Maryland 21215-0036	72 hou	eted	15. Decedent's Ed (Specify only highest gra	lucation		16a. Deced			tion uring most o	of working		16b. K	(ind of Busine	ess/Indu	ustry
12	within ne.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	OO NOT us	e retired)		or working					
0	filed v Hygie other t	Be Co	17. Father's Name (First, Middle, Last)	2		Compu	ter P	rogr		's Name (First, Middle,		eral G	ove	rnment
/lan	uld be Vental Irked o	To B	Robert Wienman L	/tle					Heler						
/Jan	2 sho l and l ls me		19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street a			Route Numbe	er, City o	or Town, Stat	e, Zip C	Code)
e,	1 and Health em 27		Robert Lytle Chisi 20a. Method of Disposition	n/ Son						; Jac	ksonvi		, F1.		
altimore,	Pages nent of I int: If its ury or o		1 ☐ Burial 2 🌠 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			20b. Place of Dispos cemetery, crem Chesapeake							sville		
Balti	permit. Pages Department of I Importent: If its any injury or o		21. Signature of Funeral Vignation			Ra Ra	Name an	d Address	I Facility	Cre	mation r Spri	Sei	rvices	•	
I,			23a. Part1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final	olications that cone cause on e	aused th	e death. Do not ente								1	Approximate Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)			ry Failure	2								6 months
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V	led sit	nlner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consaguence of):									
oʻ	execular and rial-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of);									
8760,	ficate be executed physician and is the burial-transit	dlcal		d										-	····
9 xo	leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out									23d. Date of	delivery	
O. B	at the deatl by the atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at tin		Ectopic pre Other (spe						Month		ay Year
S, T	res that igned b	by Pr	Part II. Other significant conditions co	ontributing to de	ath but r	not resulting in the un	derlying ca	use giver	n in Part I.		23e. Did to	bacco u	ise contribute	to the	cause of death?
ecords,	w require been si should b									_	1 🗆 Yı	es 2(□ No 3 □	Probab	ly 4X Unknown
	The larate has	Completed									24a. Was a autops perform	sy med?	24b. Were prior to death	o comp	y findings available letion of cause of INo
Vital	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital:							Check only on	ne)			
on of	I or Attending Physician: after death. Director: After this certific: I in by the funeral director,	lon: To	27. Manner of Death 1 ∇ Natural 5 □ Pending	28a. Date o	npatient of Injury on, Day Y	28b. Time of	28	lc. Injury a Work?	at	28d	5 Reside	ence 6 ow injur	6 □Other (S) y occurred	pecify)	
Division	or Attendation distribution of Attendation of the Colorism Director: in by the	ertificati	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	200. Flace	of Injury g, etc. (· At home, farm, stre Specify)	M et, factory,		es 2 □ No	_	Location (St City or Town	reet and 1, State,	d Number or)	Rural R	oute Number,
_	To the Hospitel or within 24 hours aft To the Funeral Dis completely filled in	edical Ce	Check only 2 Medical Exam	rsician: To the iner: On the ba	best of r	ny knowledge, death	occurred a	t the time	, date and p	place, and	due to the ca	ause(s)	and manner	as state	e cause/s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and mann	er stated	d.		License					e signed (Mo		
	/		Jund M	Su	nel	Ump		35996	5		Αυ	ıgus	t 12,	200	4
	15		30. Name and address of person who c					#1.0)() t/b~	ator					
	Sta	te	Linda M. Burrell, 31. Date filed (Month, Day, Year) AUG 1 8 2004	3 % Re	gistrar's	Signature /	DIVG	1/40	o wne	acon	, FID ZU	JUZ			
	Registra	ar	AUG 1 3 ZUU4	CA	distant	P	pour	Car							

		1 - For State Registrar	State o	f Marylan		artmen rtificate			and M		giene	0.0	0550
Dhye	-:	1. Decedent's Name (First, Middle, L	ast)							2. Date of De. Month	ath Day	Year	3. Time of Death
Physi /Med		Catherine		Ε.		Campbe				08/	08/2	2004	11:30 P M
Exam	iner	4a. Facility Name (If not institution, g				4b. City,	~	Location o) =		ty of Deat	h
		5. Social Security Number 6.		7 O S P / 7 i 7. Age (In yrs.		If Under		If Under:				1/A	hplace (State or Foreign
Funera Directo		040–34–1416 Usual Residence of Decedent	1 M 2 NF	66	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 1-24-	y, Year) 38	Co	S.C.
/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
Man B-1 sh	ţ	Md. NA			Balti	imore							1X1Yes 2 ☐ No
th the	lrec	10e. Street and Number				10f. Zip	Code				10g, Citizen of		untry?
ath w	ra i	2202 Pinewoood P					21214				USA		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Plygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Modical Execution could	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Fo	2 [X No ⁄e		Was Deced If Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	Spec	ack, White	ncan Indian, e, etc. Black
21215-0036 ad within 72 hours aff giene. ar than "natural", or if I'v Madical Extern.		15. Decedent's	Education	UNK.	16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of I		
215 27 ale 18	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1		(Give	kind of woi DO NOT us	k done d	luring most	t of worki	ng			,
212 d with	E O	Elomoniary/Goodinary (G 12)	- Conlogo (1		<u> </u>	Posta:	L Se	cvice			U.S. I	Post	Office
be filed htal Hygind other	Be	17. Father's Name (First, Middle, La	st)	_							Maiden Suma	_	
aryla should be ind Ment marked	၉	Charles		Ant	_				llen		Bour		
Maryland of 2 should be file th and Mental Hy 27 Is marked oth	170	19a. Informant's Name/Relationship		ula da a ua	1	•					er, City or Town	n, State, Z 21206	,
Te, M 1 and 1 Health tam 27		Wanda Baker 20a. Method of Disposition	Daug	hter	Place of Dispo			Ave.,		timore,	20c. Location		
ages nt of the		1 🔀 Burial 2 ☐ Cremation 3		State	cemetery, crei	matory or o	ther plac						
Baltimore, permit. Pages 1 a Department of Hes Important: If item	ٺ	' 4 ☐ Donation 5 ☐ Other (Special Service Licenses)			Parkwoo	od Cer 2. Name an			8–13 ×		Baltin Oltimore		
Deperation and leaves	BOOG	X hond	Plila	Hirle	h			H. Ea		1101	E. No	cth A	
Physicia /Medica	_	23a. P. 11 Inter the "isease, or co s pot", or heart failure. List on Imme the Cause (Final disease or condition resulting in death)	ly one cause on e	SE/	osis	ter the mod	e of dying	g, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Between Onset and Death
1760, It be executed WE IT	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	(or as a consequence of a consequence of as a consequence of a conseq	TE B quence of):	ACTO	ERI	AL	PER	2170N	1775		
I Records, P.O. Box 68760, The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ☐ Feta ant at time of c	al death 3[⊒Ectopic pr ⊒ Other (sp						ate of deli	very Day Year
ds, P. uires that the signed by the details the detail	þ	Part II. Other significant conditions END STAGE	_				ause give	n in Part I.			obacco use cor	atribute to	the cause of death?
Vital Records, rsician: The law requires t scartificate has been signe lirector, page 2 should be or	Completed										rmed?	prior to death?	topsy findings available ompletion of cause of
	e C	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes		1 🗆 Yes	212 No
/sicle	To B	examiner?	Hospital: 1	npatient 2	ER/Outpatier	nt 3□ DC	Othe				tence 6 🗆 Ot	her (Spec	eifv)
Division of Vital To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I		27. Manner of Death Natural 5 Pending Accident investigat	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		8c. Injury Work		1		now injury occu		,,
Divisio the Hospitel or Attandi thin 24 hours after death. o the Funaral Diractor: A	Certification:	3 ☐ Suicide 6 ☐ Could not determine	280. Flace	of Injury - At h ng, etc. <i>(Speci</i> i	ome, farm, sti fy)	reet, factory	, office		1	28f. Location (5 City or Tox		ber or Ru	ral Route Number,
se Hospit 24 hours sa Funara	edical (Physician: To the aminer: On the band man										
To the Ho within 24 I To tha Fu completely	Me	29b. Signature and title of certifier				- 1		number			29d. Date sign		
		Sommar	MD			D	00	606	87		08/0	9/2	004
8		30. Name and address of person who Sony M TH	o completed caus	se of death (Iter	m 23a) (Type,	Print) CH K	PAU	EM	BU	D Br	ALTIM	ORE	-21239
	State	31. Date filed-(Month, Day, Year)	32. F	legistrar's Sign	ature	,							
Regi	strar	AUG 1 3 200	14 Se	eva	4	Asa	1						

DHMH 17 Rev 1/2001

ORIGINAL

			- For Amend Item#	16a, b, per FH,	nd / Depa 334 ,88	artment of L Tificate of 2	lealth and N Death	1ental Hyg	giene Reg. NØ. () ()	1. 25533
	Physici		1. Decedent's Name (First, Middle, La					2. Date of Dea Month	ith Day	3. Time of Death
	/Medic	al	BYRD 4a. Facility Name (If not institution, giv	RUTHERF	FORD	COHE	Location of Death	AUGUST	10, 200	
	Examin	er	HOSPICE OF BALTI		Γ CTR.	40. Ony, 10mil, 0	TOWSON			ALTIMORE
	Funeral		5. Social Security Number 6. S 123-22-4391	ex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAY 8,	Year)	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	,,,				MAT 0,1	1920	0K
	the Marylan 28e-f show	5	10a. State 10b. County 0		ity, Town or Lo	cation GRASONVIL	1.5			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28e-f	Director	10e. Street and Number	JEEN ANNE		10f. Zip Code	.LC		10g. Citizen of W	^
	23s or		136 OYSTER COVE				21638			USA
336	urs after dea ai', or items	by Fun	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🕅 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. WHITE
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked othar than "natural", or items 23a or 28e-f show ther traumatic avant, the Madical Evarti act matt by multified at	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	/TELL 05145	ation during most of work Homemak TERY	ing er	16b. Kind of Bus	ome
d 2	filed v Hygle other t		17. Father's Name (First, Middle, Last,	4	TAIR	VIEW CEPIE	18. Mother's Nam	e (First, Middle,	MESTITE Maiden Sumame	D, NEW JERSEY
ylan	2 should be filed within and Mental Hygiene. Is marked othar than raumatic avant, the Ma	To Be	NEELE		BANK	S	BETTY			HANN
Mar	d 2 sho th and 7 is my traum		19a. Informant's Name/Relationship (PHIPPS MORAN / Da	**			and Number or Rur D LANE -			
e,	s 1 and the strain train 2 other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		Date		City or Town, State
Baltimore,	ment crant trant: If		1 X Burial 2 ☐ Cremation 3 X `4 ☐ Donation 5 ☐ Other (Specif	y) FA	IRVIEW	CEMETERY	8/12	the second secon		D, NEW JERSEY
Ball	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 Is any injury or other tra once.		21. Signature of Funeral Ser ice Lice		8	900 REIST		ROAD - P	IKESVILI	E, MD 21208
. 6			23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final	one cause on each line.		,	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
- Lan	/Medical		disease or condition resulting in death)	a Breast Due to (or as a conse		10er				years
0]	Examiner	_	Sequentially list conditions,	b	duence off.					
(a sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lister Section 1) that initiated events	C Dae to (or as a conse	iquence oi).					
, 00 , 00 , 00	la la	I Exa	resulting in death) Last	Due to (or as a conse	equence of):					
6876	ficat ph sic s the	edical		_ d						
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 proports? 1 □ Yes 2 □ No	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[Ectopic pregnancy Other (s <i>pecify)</i>			23d. Date Mont	of delivery th Day Year
ے مـ	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions of		sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contril	oute to the cause of death?
rds,	w requires that s been signed I should be det							1 □ Y	es 2 No	3 ☐ Probably 4 XUnknown
Division of Vital Records,	The law rec ate has bee page 2 shor	Completed						24a. Was a autop. perfor	sy pr med? de	ere autopsy findings available for to completion of cause of sath? Yes 2 \sum No
/ital		Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat	h (Check only or	ne)	
of	Phya er this c eral dir	1: To	1 Yes 2 No 27. Manner of Neath	28a. Date of Injury	ER/Outpatier 28b. Time of	28c. Injur	y at	me 5 Resid 28d. Describe h	ence 6 Other ow injunoccurre	(Specify) NOS PICE
ion	or Attanding I after death. Diractor: After in by the funer	ation	1 Natural 5 Pending investigatio		Injury	M 1	k? Yes 2 □ No			
Divis	el or Att s after d il Diract id in by t	Certification;	3 Suicide 6 Could not b 4 Homicide determined		home, farm, str cify)	eet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural Route Number,
	To the Hospitel or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (nysician: To the best of my kr miner: On the basis of examin and manner stated.						
	Vithir To th	ž	29b. Signature and title of certifier	00		29c. Licens				(Month, Day, Year)
	20		30. Name and address of person who	completed cause of death (Ite	om 22a) /Tues	Print)	20 SC	5.	Trois	1 10 0009
	20		31. Date filed (Month, Day, Year)	22. Registrar's Sign	66	01 N	. Chair	LRD 87	Balto	1 10 2004 une MD 21204
	Sta Regista			3 2004	was sto	poets				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		State of Marylar	nd / Department of Health and N Certificate of Death	2001 2001
		Decedent's Name (First, Middle, Last)	Certificate of Beatif	Reg. Nø. 3. Time of Death
	Physician /Medical			Month Day Year 10 40 A4945+ 10 2004 10 4
	Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Jown, or L	ocation of Death 4c. County of Death
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs	Months Days Hours Min.	8. Bate of Birth (Month, Pay, Year) Sept. 17, 1946 Mary Land
	Director	212-46-5605 1MM 2LIF 57	Yrs.	Sept.17,1946 Maryland
	death with the Maryland ims 23e or 28e-f show if must be notified at meral Director		ty, Town or Location	10d. Inside City Limits 1 ☐ Yes ②□No
8	with the Mary or 28a-fish be notified Director	Maryland Baltimore P	erry Hall	10g. Citizen of What Country?
E	23a or unt be		21128	United States
2	fier death virter rust	11. Marital Status 12. Was Decedent Ever in I	U.S. 13. Was Decedent of Hispenic Origin? (Set nam If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- b Rican, etc.) 14. Race - American Indian, Black, White, etc.
rispens 120	within 72 hours after ene. than "natural", or its he Medical Examina		1 ☐ Yes 2 🗷 No Specify:	Specify: White
200	72 hou nature	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	l6b. Kind of Business/Industry
121	ed within 72 ho ygiene. her than "natura nt, the Medical Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Central Office Foreman	n Verizon
7 Dr	Hygi Int.			ne (First, Middle, Maiden Surname)
ylar	Men Men Trick	william H. Crispens, Jr.	Thelma	
Mar	d Z La	19a. Informant's Name/Relationship (Type, Print) Suzanne E. Crispens (Wife)	11 Chapel Manor Court	rel Route Number, City or Town, State, Zip Code) Perry Hall, MD 21128
ore,	of Health Item 27 I	ZOA. INIBITION OF DISPOSITION	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
· · / mil	ment cannot cann	4 □ Donation 5 □ Other (Specify)	lto-Washington Cremator	
Ball	permit. Peges 1 en Depertment of Heat Important: If item 2 any Injury or other once.	21. Signature of Funeral Service Licensee	Bradley-Ashton-Mat # 2134 Willow Spring	thews Funeral Home, Inc. Road Baltimore, MD 21222
	(5.55±5)	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause of the complete of the death shock, or heart failure.	th. Do not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between
•	Physician /Medical	Immediate Course (Final	1	Onset and Death
	Examiner	disease or condition resulting in death) a. Due to	or as a consequence of):	Typu
	7 # S	Bogs	n metartais	
	be executed sician encorporate buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	or as a consequence of):	
8760	se be	Cause (Disease or injury that initiated events Due to (or as e consequence of):	
Box 6	eath c ettend I for us		authing in the underlying square given in Part I	23b. Did tobacco use contribute to the cause of death?
P.O.	v requires that the death certific been signed by the ettending p should be deteched for use es	Pert II. Other significant conditions contributing to death but not re	Sulfing in the underlying cause given in Fact.	1 No 3 Probably 4 Unknown
ds, l	signed d be de			24a. Was an autopsy 24b. Were autopsy findings
Records,	The law require set has been single page 2 should			performed? available prior to completion of cause of death?
	sician: The law s certificate has but director, page 2 s			1 Ves 2 No
Vital	entifice actor.	25. Was case referred to medical	Othor	ath (Check only one)
₹ 5	Physic rthis c orel dire		28b. Time of 28c. Injury at	lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred
ion	ath. r: After	1 CNatural 5 Pending (Month, Day Year) 2 Accident investigation (Month, Day Year)	Injury Work? M 1 Yes 2 No	
Division	is of Attanding P is ofter death. By Director: After the din by the funers.	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office ify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attanding Physician: The is within 24 hours effer death. To the Fureral Director: After this certificate has completely filled in by the funeral director, page		owledge, deeth occurred et the time, date and place etion and/or investigation, in my opinion, death occu	a, and due to the ceuse(s) and manner as stated. strength of the time, date and place, and due to the cause(s)
	of the Frithin 2 of the Frithin 3 of the		29c. License number	29d. Date signed (Month, Day, Yeer)
	F 5 F 0	> Staller	m 027925	F/11604
1.01	ıD.	30. Name end address of person who completed cause of death (Ita	om 23e) (Type, Print) 615 Noe Axid neture Sparks	Nd Bel An Mn 21014
	State	31. Date filed (Month, Day, Year) 32. Registrar's Sig	neture /	1 / Col) for you will
	Registra		D Boaks	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Kathleen Dively 2004 ugu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HO5P eda Square 05 TIMO Franklin If Under 24 Hrs. Birthplace (State or Foreign Country) Under 1 Year 8. Date of Birth (Month, Day, Year) March 31,1924 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√2 F 80 210 12 3988 Director Pennsylvania Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a, State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 € No Essex Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō 21221 USA 24 Helmsman Ct. or Items 23a by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ∐Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Marýland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, important: if frem 27 is marked other than "na any injury or other traumatic aven" Elementary/Secondary (0-12) College (1-4or 5+) Supermarket 12 Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anne Brown Jed Covert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24 Helmsman Ct. Baltimore, Maryland 21221 Allen Daniel Dively Jr. (Son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 8/11/2004 Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service 1407 Old Eastern Avenue Essex, Md. 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ef Immediate Cause (Final disease or condition resulting in death) Pnysician 05 3 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 Ø No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes 2 Z No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Înpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 Z No 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification; After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Thomicide in 24 hours.
the Funeral Directory 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the within 29b. Signature and title of certifier 2

State Registrar

DHMH 17 Rev 1/2001

1. nSquar

Drive Bolt

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kothorina

AUG 1 3 2004

31. Date filed (Month, Day, Year)

y900 Frank

32. Registrar's Signature

State of Maryland / Department of He 1- State AMEND ITEM #12 PER FH G834 8/201/04te Per FD	ooth
1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physician Stanley Duda	August 10 2004 9:45P
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	
Franklin Square Hosbital Center Rosec	dale Baltimore
Months Days	ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country)
Director 216 18 3913 1 M 2 F 80 Yrs. World's Days	July 31,1924 Maryland
9	10d. Inside City Limi
Maryland Baltimore Middle River	1 □Yes 2vŢN
Maryland Baltimore Middle River Maryland Baltimore Middle River 106. Street and Number 107. Zip Code	10g. Citizen of What Country?
1711 Wilson Point Rd. 21220	USA
10c. City, Town or Location 10c.	anic Origin? (Specify Yes or No- Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc.
1 Never Married 25 Married 1 XXes 250 No 1943 No 3 No	Specific
3 Widowed 4 Divorced Sear or Dates: 1946 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Elementary/Secondary In Secondary (0-12) College (1-4or 5+) Elementary/Secondary In Secondary	WILLCE
TO T	on 16b. Kind of Business/Industry ing most of working
Elementary/Secondary (0-12) To be seen and the secondary (0-12) College (1-4or 5+) Elementary/Secondary (0-12) To be seen and the secondary (0-12) To be s	
To post the page of the page o	3. Mother's Name (First, Middle, Maiden Sumame)
Peter Duda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	Aniela Korytkowski
17. Father's Name (First, Middle, Last) 18. Peter Duda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and 191) 1711 Wilson Point	Number or Rural Route Number, City or Town, State, Zip Code)
Elsie Duda (Wife) 1711 Wilson Po	int Rd. Baltimore, Md. 21220
20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary 21. Sign fure of Funeral Service Licensee 22b. Place of Disposition (Name of cemetery, crematory or other place) Holy Rosary 22c. Name and Address of Bruzdzinski	Date 20c. Location - City or Town, State
4 Donation 5 Other (Specify) Holy Rosary	8/14/2004 Baltimore, Maryland
Maryland Baltimore Middle River 10a. State Maryland Baltimore Middle River 10b. County Maryland Baltimore Middle River 10c. City, Town or Location Middle River 10c. Zip Code 21220 11. Marital Status 11. Marital Status 11. Marital Status 11. Never Married 22 Married 3 Widowed 4 Divorced 11. Specify only highest grade completed) 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hisp If Yes, specify Cuban, 11. Yes 22 No. 12. Was Decedent Status 11. Yes 22 No. 12. Was Decedent's Usual Occupation (Specify only highest grade completed) 12. Signify only highest grade completed) 13. Was Decedent of Hisp If Yes, specify Cuban, 14. Yes 22 No. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done durn life. Do NoT use retired) 17. Father's Name (First, Middle, Last) Peter Duda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Complete) 1711 Wilson Point 20b. Place of Disposition (Name of camelery, crematory or other place) 1711 Wilson Point 20c. Method of Disposition 1 Survice Street and Stree	of Facility Funeral Home P.A.
1/07/01 N. DUTANUMAS / 1/07 01d Pag	storn Aronio Essay Md 21221
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, stylick, or heart failure. List only one cause on each line. Immediate Cause (Final	such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
Physician disease or condition resulting in death) Physician disease or condition resulting in death) a. Death of or as a consequence of the condition resulting in death)	otic Hyperalycemia
Examiner Dogu Mania	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Fire United Transport of the cause (Disease or injury that initiated events) c. Diobetes Melitus	
of the property of the propert	Farction
of the state of th	Farction
of the state of th	Farction 23d. Date of delivery Month Day Year
To see the size of the second	
To several property of the pro	Month Day Year
To soluting in death) Last Due to (or as a consequence of): d. ACUTE My Cardia In less the policy of the pol	Month Day Year
To soluting in death) Last Due to (or as a consequence of): d. ACUTE My Cardia In less the policy of the pol	Month Day Year n Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 ⋈ No 3 □ Probably 4 □Unknown
The solution of the state of th	Month Day Year 1 Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
The solution of the state of th	Month Day Year 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy findings available prior to completion of cause of
The solution of the state of th	Month Day Year 1 □ Yes 2 No 3 □ Probably 4 □ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No
The state of the s	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
The state of the s	Month Day Year 1
The soluting in death) Last Continued by the continued	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
To voice the past of the past 12 months? If FEMALE: 23b. Was decedent pregnant in the past 12 months? If Jess 2 No 9 Unknown 1 Jess 2 No 9 Unknown 25c. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 25c. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 26c. Manner of Death 1 No path of the past 12 months? 1 Yes 2 No 9 Unknown 26c. Manner of Death 1 No path of the past 12 months? 26c. Manner of Death 1 No path of the past 12 months? 26c. Manner of Death 1 No path of the past 12 months? 26c. Manner of Death 1 No path of the past 12 months? 27c. Manner of Death 1 No path of the past 12 months? 28d. Date of Injury - At home, farm, street, factory, office building, etc. (Specify)	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
The solution of the past 12 months? The past 12 mo	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
The solution of the past 12 months? The past 12 mo	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
Due to (or as a consequence of): Acute MyoCardial Indiana MyoReplace MyoRe	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
The solution of the past 12 months? The past 12 mo	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1
Due to (or as a consequence of): ACUTE My Card Image Im	Month Day Year 23e. Did tobacco use contribute to the cause of death? 1

			1 - State of Ma	aryland / Depa	artment o			nd M		00	01	And have been	* (1) **1
	Physic	ian	Decedent's Name (First, Middle, Last)		uncate	01 1	Calli		2. Date of Dea		Year	3. Time	
	/Medi Examir		Thelma Marie Degener 4a. Facility Name (If not institution, give street and number)		4b. City, To	wn orl	ocation of		August)4 nty of Death	4:20	рт м
	Exami	iei	Gilchrist		_	wsor		Deau			timor	P	
	Funeral		015 00 0050	(In yrs. last birthday)	If Under 1 \		If Under 24		8. Date of Birth	1		place (State	or Foreigr
Ĭ	Director		215-22-6370 1 M 2 F 9	O Yrs.		Jujo	1,00,0		Dec. $2, 1$	913	Mary	länd	
	yland Now		10a. State 10b. County	10c. City, Town or Lo	cation							10d. Inside	City Limits
	a-fsh	ctor	Maryland Baltimore	Timoniu	n							1	s 2V No
	or 28	Director	10e. Street and Number		10f. Zip Co	ode			1	0g. Citizen o	of What Cou	ntry?	
	s 23a		2113 Reuter Road			1093				USA	<u> </u>		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. item 27 Is marked other then "natural", or Items 23a or 28a-f show other traumetic event, the Medical Examination at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 Married 15 Yes Give Year or Dates:	0	Was Deceden fYes, specify 1 ☐ Yes 2		panic Origir , Mexican, f Specify:	n? (Spec Puerto R	cify Yes or No- lican, etc.)		ace - Ameni lack, White,		
2-0	72 hound	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual C	Occupati	ion			16b. Kind of			
21215-0036	Aithin he.	mpie	Elementary/Secondary (0-12) College (1-4or 5-	+) life. L	kind of work o	retired)	ring most o	r workin	9				
2	iled w Tygier ther ti	S	1Z 17. Father's Name (First, Middle, Last)	Sale	28		0.14-44-		(F)		weler		
Maryland	should be I nd Mental I marked of Imetic eve	To Be	Karl Gartner					i i i da	(First, Middle, I	Reisin			
ary	2 shot and N Is mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (S	treet an			Route Number		_	Code)	
	and and marking markin		Yvonne M. Degener / Daughte		Reute		oad		imonium	, Mary	land 2	21093	
5	Pages 1 ar nent of Hee ent: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other	of r place)		Da	te	20c. Location	- City or To	wn, State	
Baltimore,	교원문중		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	Parkwood				/12/	′ 04	Parkvi			and
g R	perm Depa Impo any i		21. Signatura di Punetal Service Licensea		Name and A			57 L	lome,In		York		1
M	HUN		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of	f dying.	such as car	rdiac or	respiratory arre	est.		Approxima	ate
	Physician		Immediate Cause (Final disease or condition	consequence of):	thr. 1	Ve	200	7	ارجم > (0.6-		Interval Be Onset and	
ï	/Medical		resulting in death) a. Due to (or as a	consequence of):	- /	- 1		- 10	300	11	. 1	Me	214
	Examiner	er	Sequentially list conditions, b	03	steop	20 V	03,5	w	cia n	1049	ple		
	ted nsit		if airy, leading to immediate cause. Enter Underlying Cause (Disease or injury	солѕециелсе оі):	719 0	N	CANA	pr	2 1100	١			
ŕ	cate be executed physician and the burial-transit	Examin	that initiated events	consequence of):							-		
2/60	ysicia ysicia	dical	d.										
٥		Medi	IF FEMALE:								Ш,		
.O. BOX	death e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Fetal death 3	Ectopic pregn Other (specif						ate of delive onth	,	Year
ν, T	requires that the een signed by th hould be detache	by PI	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause	e given	in Part I.		23e. Did tob	acco use cor	tribute to th	e cause of	death?
cora	w require been sig should b		Congestive Heart	FAILURE					1 □ Ye	s No	3 🗌 Proba	abiy 4 🗌	Unknown
Ū	aw 1s b	ompleted	Gastro intenstinal BO	elding					24a. Was ar		Were autop	sy findings	available
<u> </u>	Th ate pag	Con	Diabete mellitus o	SSTRECT	rive la	ery	dise	95.	perform		prior to condeath? 1 Yes	2□ No	200
Vilai	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? Hospital:			O++			Check only one			71	
5	£ 5 =	\vdash	27. Manner of Death 28a. Date of Injury	28b. Time of		Injury at Work?			5 Resider			407	110
0	Attending ir death. ector: After by the fune	atlo	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury			s 2 No			,,			
UNISION	To the Hospitel or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	et, factory, off	fice		281	Location (Str. City or Town,	eet and Num State)	ber or Rural	Route Num	iber,
_	spitel		29a. Certifier Certifying Physician: To the best of	my knowledge death	occurred at th	a time	date and pl	lace and	d due to the en	100(0) and m			
	he Ho in 24 h he Fui	edical	(Check only one) 2 Medical Examiner: On the basis of each and manner state	xamination and/or inve	estigation, in n	ny opini	ion, death o	occurred	at the time, da	te and place,	and due to	the cause(s	i)
	To 1 To t Comp	Σ	29b. Signature and title of certifier)	29c. Lic	cense ni	umber		29	d. Date signe	ed (Month, D	ay, Year)	
			If Hithmy Kil	y and	D	2	520	5	/	40gc	578	-200	سرر
	10		30. Name and address of person who completed cause of de	M (L Z	rint)	A-	Cha	rle	St. i	tage	Md	200	.01
	Sta	100	31. Date filed (Month, Day, Year) 32. Registrar	s Signature	,								
	Registra	ar	AUG 1 3 200₽	Beggerra	19	10	ands	,	r				

			1 - For State Registrar	State of Man			of He	ealth a		lental Hy	giene	nble.	25538
	Physic	ian	Decedent's Name (First, Middle, Last							2. Date of De	eath Day	Year .	3. Time of Death
	/Medi		JOAN M.	Dopko	MSKI	,				August	12	2004	9:32 AM
	Exami	ner	4a. Facility Name (If not institution, give	it Hospic		4b. City, To	1 H	MOY (4c. Count	y of Death	
	Funeral Director		5. Social Security Number 6. S. 21 28 7925 1 Usual Residence of Decedent	9x 7. Age (l. □ M 2 1 F	n yrs. last birthday) Yrs.		Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	rth ay, Year) 1933	9. Birthpi Coun MA1	ace (State or Foreign try).
	land ow		10a. State 10b. County	10	Oc. City, Town or Lo	cation						1/	Od. Inside City Limits
	Mary	ţō	Maryland		Baltim	570						,,	1 Yes 2 No
	r 28e	Director	10e. Street and Number			10f. Zip Co	ode				10g. Citizen of	What Coup	
	th wit	a D	1004 S. Po	tomac St			2122	24		1	Unite		Ates
	Sme Sme	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Deceden	nt of Hisp	panic Origi	in? (Spe	cify Yes or No Rican, etc.))- 14. Ra	ce - America	an Indian,
9	or the	Fu	1 Never Married 2 Married	1 Yes 2 No					Puerto I	Rican, etc.)	-	ck, White, e	otc.
8	within 72 hours after deeth with the Maryland ene. than "naturet, or items 23a or 28e-f show the Medical Evantrier must be rediffied at	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2		Specify:			Specia	y. Wh.	15
5	n 72 "nat	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	lent's Usual C kind of work o	done du	ion ring most o	of workir	ng	16b. Kind of 8	usiness/Ind	ustry
12	withi ene. than	m C	Elementary/Secondary (0-12)	College (1-4or 5+)	. 3	OO NOT USE T	,				Dwn	Homi	>
9	filed Hygi other ent, I		17. Father's Name (First, Middle, Last)		11011	IC MARK		8 Mother	s Namo	(First Middle	Maiden Sumar		
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-1 show or other treumatic event. If a Medical Enaminer must be notified at	To Be	Frank Stoke	:5					1ACY		rmody	110)	
ary	shou and N	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (St	treet and				er, City or Town,	State Zin I	Code)
	1 and 2 Health a tem 27 is		Edward Dopkonski	1 300138	2908	Dillon	St				MD.	212	
ore	of He of He fitem		20a. Method of Disposition 1 Burial 2 Cremation 3	2	Ob. Place of Dispo- cemetery, cren	sition (Name o	of r place)		Da	ate	20c. Location	City or Tov	vn, State
Ĕ	Pages ment of ent: If it ury or o		Donation 5 ☐ Other (Specify)		incred Hea	1 I 1	25 V3	Av	a, il	2004	Dundal	K. MA	ingland
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licens			Name and A	ddress	of Facility	1 2	ome o	1 -0 1	•	F.A.
_	20 E 8 8		-11	4	7	110 50	liers	91	RJ.	Dund	ALV MA		1222
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the ne cause on each line.	death. Do not ente	er the mode of	f dying,	such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	From	, nega	tin	L Rey	pri.	•			Onset and Death
	Examiner			Due to (or as a co	nsequence of):	0							
		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a co	usednence ot).								
X	ansit	ᇤ	Cause (Disease or injury										
	bratecuted iciam and burial-transit	Examlner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):								
928	cate be	dlcal		d									
9	ntifica ng ph as th	Med	IECENALE.										
Box	death certifica attending ph for use as th	Physiclan/Me	zoo: Trab account program	3c. If yes, outcome of pr 1 Live birth 2 □		Ectopic pregna	2001				23d. Dat	e of delivery	
о. П	e dea he at ted fo	sicl	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time 9☐Unknown		Other (specify					Moi		ay Year
P. 0.	d by t	Phy	9 Unknown										
ŝ	law requires that the death certific as been signed by the attending p 2 should be detached for use as	þ	Part II. Other significant conditions co			derlying cause	e given i	in Part I.					cause of death?
0	requ	eted	1 mg o con a	line in face	it im				_	1 🗆 Y	es 2 🗆 No	3 Probab	oly 4 Unknown
3ec	9 - 9	Completed	CVA						_	24a. Was a autops	sy p	Vere autops	y findings available pletion of cause of
Vital Records,	iician: The l certificate ha rector, page									perform 1 Yes	med? d	eath?	S évio
<u> </u>	or Attending Physician: ifter death. Director: After this certific in by the funeral director.	o Be	25. Was case referred to medical examiner?	lospital:						Check only on			
Division of	Phy ar this aral d	H 1	1 Yes 2 No	1 LI Inpatient	2 ER/Outpatient 28b. Time of	3☐ DOA	nurv at	4 Nursi	ng Home	9 5 Reside	ence 6 30 the	r (Specify)	Hospice
<u></u>	nding P tth. :: After e funer	ig l	1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Yea	ur) Injury		njury at Work?	2 □ No	20	o. Describe III	w injury occurre	9G	
N S	al or Attend after death Director: / d in by the f	ertiflcatlon;	3 Suicide 6 Could not be determined	28e. Place of Injury	At home, farm, stree			- 40.110	28	f. Location (St	reet and Numbe	or Or Rural F	Route Number
ā	s afte	Cert	4 Horricide	building, etc. (Sp	ecify)	,,,			1	City or Town	n, State)	or marant	oute reamber,
	To the Hospital or within 24 hours after To the Funerel Dire completely filled in E	edical	29a. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	sician: To the best of my ner: On the basis of examinand manner stated.	knowledge, death mination and/or inve	occurred at the estigation, in m	e time, o	date and p	lace, and	d due to the call at the time, da	ause(s) and mar ate and place, a	nner as state	ed. e cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	ense nu	ımber		2:	9d. Date signed	(Month, Da	y, Year)
,			Device B	midist . Y	หล	1	000	000	2 2		2/12	104	
	16		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, P	rint)		ے دری	2 3		0 7 1	7	
	1		GWILLAM BENI	EDICT, M.	D. , 150	w. L	-AN	JUAZ	Æ	St. B.	ltimon	-, mo	21217
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	1	-	-		7		4	
DHA	ALL 17 Day 1/22	01	AUG 1	mpleted cause of death and a second and a se	will so	Spende							

Soon

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>		lealth and N Death) 4 2	25539
	Physic /Med		1. Decedent's Name (First, Middle, Las Constance		Ay			A WOULD	Day .	Year 2004	3. Time of Death 0450 A M
	Exami	ner	4a. Facility Name (If not institution, give Harbor Hospit 5. Social Security Number 6, S	al Center		Baltir	Location of Death	o Varylani	4c. County	of Death N/A	0 130 11
	Funeral Director		219–10–7521	7. Age (In yrs. 74	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Sate of Bir 5/3/19	th 19 Year) 30	9. Birthpla Countr MARYI	ice (State or Foreign y) LAND
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo	cation				100	d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show	Director	MD ANNE ART	INDEL	HANOVE	10f. Zip Code			10g. Citizen of t	Albah Causta	1 ☐ Yes XXNo
	s 23a or	ralD	7644 HARMANS ROAL			21076			USA	Wildle Countr	y :
5-0036	or Ite	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If	Vas Decedent of Hi Yes, specify Cuba Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - Americar ck, White, et -BLACK	c.
215-(within 72 hours ene. than "netural", he Medical Exe	Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)	ucation fe completed) College (1-4or 5+)	16a. Deced (Give I life. D	ent's Usual Occupa kind of work done d OO NOT use retired,	ation furing most of worki)	ing	16b. Kind of Bu	usiness/Indu	stry
d 2121	filed with Hygiene ther the	Com	17. Father's Name (First, Middle, Last)	College (1-40r5+)	DIETI	CIAN			ARMY HOS		ı
Maryland	2 should be filed withir and Mental Hygiene is marked other than eumetic event, <u>tra Ma</u>	To Be		TTS			18. Mother's Name	LDRED	B • CO		
	is 1 and 2 show the stand and stand item 27 is mater treums		19a. Informant's Name/Relationship (7 FRANK M. DAY / HU	SBAND	7644	HARMANS	RD, HANOV	ER, MD	21076		
Baltimore,	Pages nent of H ant: If ite		20a. Mathod of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State		ation (Name of atory or other place EE MEM。 P	9)	/04 1	20c. Location - ELKRIDGE	-	
Balt	permit. Page Department of Importent: If any injury or once.		21. Signal To Funeral Service Licen		22.	Name and Address	s of FacilityHOWE	LL FUNI	ERAL HOM	Œ	MD 21207
87602	ate be executed /Medical examiner /Medical examiner /Medical examiner /Itansit exami	cal Examiner	231 Part. Enter the disease, or compositions, the introduction of	Due to (or as a consequence to (or as a consequence)	h. Do not ente	cance. Edema	, such as cardiac o	r respiratory ar	rest,	A	proximate perval Between inset and Death Month's Standard
P.O. Box 68	t the death certific: by the attending pl ached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	3c. If yes, outcome of pregnal 1	death 3□E	ctopic pregnancy Other (specify)			23d. Date Mon	of delivery th Da	y Year
	signed I	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the und	lerlying cause giver	n in Part I.		bacco use contri		
Records,	The law requir ate has been si page 2 should	Completed						24a. Was a autops perform	in 24b. W	for to comple eath?	findings available etion of cause of
of Vital	siclen: certific rector,	o Be C	25. Was case referred to medical examiner?	ospital:			26. Place of Death	(Check only on	(8)	Yes 2] No
n of		\vdash	1 Yes 2 No 27. Nanner of Death 1 Natural 5 Pending	1 Minpatient 2 L E	ER/Outpatient 28b. Time of Injury	3 □ DOA Other 28c. Injury a Work?	at 28		ence 6 Other		
Division	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor		M 1 □ Y€	es 2 No	Rf Location /St	reet and Number	or Bural Ba	Nitto Alisantos a
Ö	- 0.55		4 Hornicide	building, etc. (Specify,	···			City or Town	n, State)		
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☑ Certifying Physical (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death o ion and/or inve	eccurred at the time stigation, in my opir	, date and place, ar nion, death occurred	nd due to the ca	ause(s) and man ate and place, ar	ner as stated ad due to the	l. cause(s)
•	To T To Com	Σ	29b. Signature and title of certifier	- MD		29c. License r	-		Pugus+		*
	10		30. Name and address of person who co JANAKI DEEPAK HA	mpleted cause of death (Item 2602 HOSPITAL	23a) (Type, Pri	int) South Hp	WOVER	STREE	T, BALTI	MORE	004 T,MD 21225
	Sta Registr		31. Date filed (Month, Day, Year) ALIG 1 3	32. Registrar's Signatu	ure						
DH	/IH 17 Rev 1/20	001	HOU T 9	A CONTRACTOR	- C.	Company of the Compan					
				C	DRIGINAL						

			1 - For State	State of M	Maryland		artment o			and M		giene	and the second	20010
			Registrar 1. Decedent's Name (First, Middle,	Last)			incate	01 0	Calli		2. Date of Dea		UUU	3. Time of Death
п	Physici		Margaret Doyl								Month Aug.		^y 2004 ^{Year}	3:00 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number	ar)		4b. City, To	wn, or L	_ocation o	f Death			. County of Death	
			Eastpoint Rehal	o & Nursing	g Cent	er	Ba1	tim	ore			I	Baltimore	
	Funeral		· ·	5. Sex 7. / 1 ☐ M 2 □ F	Age (In yrs. la		If Under 1 \ Months D	Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Day		9. Birthp	lace (State or Foreign
	Director		216-20-3393 Usual Residence of Decedent	231	97	Yrs.					Dec.	26,	1907 U	nknown
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation						1	Od. Inside City Limits
	Man,	tor	Md. Balt:	imore	1	Dunda1	.k							1 ☐ Yes 2 → No
	or 286	irec	10e. Street and Number				10f. Zip Co	ode				10g. Cit	izen of What Coun	try?
	23a	Funeral Director	1046 Old North	Pt. Rd.			21	224				U.S	S.A.	
	er deg	une	11. Marital Status	12. Was Deceder Armed Force	s?	S. 13. \	Vas Deceden f Yes, specify	t of His Cuban	panic Oriç , Mexican	in? (Spec , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Americ Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	d 1 □Yes 2 [If Yes, Give Year or Dates		ωm	I□Yes 2	No	Specify:				_	ite
Ö	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-f show is Marileal Essa", in stringal be notified at	ted	15. Decedent's	Education		16a. Deced	lent's Usual C	Occupat	ion			16b. K	ind of Business/Inc	dustry
212	hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4o	or 5+)	(Give life. l	kind of work of OO NOT use r	done du retired)	ring most	of workin	g			,
2	er th	Con	Unknown			Un	known					Ur	known	
nd	be fill stal Hy od oth	Be	17. Father's Name (First, Middle, L. Unknown	ast)				1		r's Name CNOWN	(First, Middle,	Maiden	Sumame)	
<u>Ş</u>	d Mer d Mer narke	T _o	19a. Informant's Name/Relationshi	- (Time Chint)		405 14-11	- 4-1 (0							
<u>a</u>	d 2 sl th and t7 ls r traur		Dept. of Aging I	Balto. Cour	ity							-	or Town, State, Zip	*
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name i	of	1	Da	ate		Md. 2120	
OIII	Pages ent of nt: If i		1 Burial 2 Cremation 3		Bali	metery, cren to-Was	hingto	n C:	remat	. 8-8 :ory	-04	Lau	rel, Md.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or flems 23a or 28e-1 show any injury or other traumetic event, If a Marical Exacting the marker political at once.		21. Signature of Funeral Service Li			22	. Name and A	ddress	of Facility	/				
m	De Cura		Sharra	10199	ett	<u>B</u>	f3416Y		hton- w Spi	Matt	hews Fi	iner	al Home	Inc.
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caus	d the death.	. Do not ente	er the mode of	f dying,	such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Athe	erosc	ient	ie C	an	eio L	rasci	ular	0	Jease	Onset and Death
	/Medical Examiner		resulting in death)		as a consequ									
		-	Sequentially list conditions,	b. Due to for a	is a consecu	enos offi								
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
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8760,	icate be executed physician and s the burial-transit	dical		d										
Ó	artifica ing ph e as ti	Med	IF FEMALE:											
Вох	death certific e attending p ad for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 ☐ Fetal o	death 3	Ectopic pregn					2	23d. Date of deliver Month	y Day Year
o.	0 0 0	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant 9⊡Unknown		atn 5∟,	Other (specif	y)						,
<u> </u>	The law requires that the ate has been signed by the page 2 should be detached.	by Physician/Me	Part II. Other significant condition	s contributing to death	but not resul	lting in the ur	derlying caus	e given	in Part I.		23e. Did to	bacco u	se contribute to the	e cause of death?
rds	quires n sign	d be									1 🗆 Y	es 2[□No 3 □ Proba	bly 4 Gunknown
000	aw requir is been si 2 should	Completed									24a. Was a		24b. Were autop	sy findings available
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'ita	ysicien; The iis certificate ha director, page	Be	25. Was case referred to medical examiner?	T. L.				2	26. Place	of Death (Check only or			
7	Physic this co	ပ္	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inpa		R/Outpatient		Other:	4 Mur				Other (Specify)	
Division of Vital Records,	ding Phy h. After thi funeral c	lon:	27. Manner of Death Natural 5 ☐ Pending	28a. Date of In (Month, D	Jury Day Year)	28b. Time of Injury		Injury a Work?			d. Describe ho	ow injur	y occurred	
isic	or Attendi after death. Director: A in by the fi	ficat	2 Accident investiga 3 Suicide 6 Could no	t he	niury - At hon	ne, farm, stre			s 2 🗆 N		f. Location (Si	reet and	d Number or Rural	Route Number
<u>S</u>	al or A after 1 Direct	Certification:	4 Homicide	ed 28e. Place of I building,	etc. (Specify)		,,,	,,,,,			City or Town			, 10010 , 1001,
	ospita hours unere ly fille	al C	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the bes	st of my know	ledge, death	occurred at th	he time,	date and	place, an	d due to the ca	ause(s)	and manner as sta	ited.
	To the Hospital or Attending Physicien: within 24 hours atten death: To the Funerel Director: After this certifical completely filled in by the funeral director.	ledical	One)	caminer: On the basis and manner:	stated.	on and/or inv				1 occurred	at the time, d	ate and	place, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifier	644				cense r		/	2	9d. Date	signed (Month, D	ley, Year)
			70	, and				1)	> = 0	41		TUS	us r b	2004
	2		30. Name and address of person w	no completed cause of	death (Item :	23a) (Type, F -/c 7	Bac.	Ki	Rive	nec	ek Ro	ad	Balti	2004 noe Maylad
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	9 1	oorks	/						0101
	Registr	ar	AUG 1 3 2004	penge		19	ours							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 3. Time of Death 2. Date of Death Month August Day Year **Physician** 1045aM 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner timore rs. last birthday, If Under 24 Hrs. Birthplace (State or Foreign
 Country) **Funeral** 1 ☐ M 2 🕳 F 7-26-9150 Yrs. Director sual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at Himore 1 Yes 2 No **Funeral Director** 28e-f 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code or Items 23e 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Yo Specify Be Completed by ack 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OONOT use stire 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry /Secondary (0-12) other then College (1-4or 5+) shie treumetic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle_Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hient: If item 27 Is marked out 19a. Informant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent; If item 27 Is eny injury or other treu once. 20b. Place of Disposition (Name of 20c. Low tion - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYCOSIS /Medical Due to (or as a consent once of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directly (or as a consecuence of): Completed by Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 ☐ Other (specify) ed by the detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Inter (Specify) 1 ☐ Yes 2 ☐ No 70 2 ER/Outpatient 3 DOA this 27. Man of eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4085 2004 completed cause of death (Item 23a) (Type, Print) Baltmore Riseberg 21202 Paul 42.9 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** L 128 0 200H Wasten ero)E /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltima MD Medical(GH MUCOSIT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 3 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year Days Hours Min 1□M 2□E Yrs 1942 Pennsylvania Director 219-40-2008 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Modical Examiner year by notified at 1 X Yes 2 ☐ No Md. Harford Bel Air Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1015 E. MacPhail Road or Itams 23a 21015 United States death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. I hoportant: If liem 27 is marked other than "natural", or liar any injury or other traumatic event 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) general foreman stee1 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emily Schoffstall Marlin Leroy Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1015 E. MacPhail Road, Bel Air, Maryland 21015 Patricia Evans/wife Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/14/04 * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular Pnysician erebro /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause in a Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2□No 2 No Yes 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2
Date of Injury
(Month, Day Year) 2 Yes 2 □ No 2 ER/Outpatient 3 DOA this funeral 28c. injury at Work? ner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical xamingr: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 10060225 8 30. ame and address of parent who completed cause of death (Item 23a) (Type, Print) 22 J. Creane Menaker 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2004 Registrar

			1 _ State	State of Maryland		artment of Ho			0001	05010
			Registrar 1. Decedent's Name (First, Middle, Last)		001	tineate of L	- Calli	2. Date of Death	g. No.	3. Time of Death
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Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licenses	Watter	1.3	Name and Address Narch F.H.			ore, Md. North Av	21202 e.
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	ding Ph h. After th funeral		27, Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury Work	at ?	28d. Describe how	v injury occurred	
Division	Attending r death.	atlc	2 Accident investigation	(, ==, -==,	,,		es 2 No			
Vis	or Attend after death Director: /	tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	et, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
O	al or A s after of in b	Certification:	4 <u></u>	building, old. (opediny)				Only G. Form,	Oldio)	
	Hospital or 24 hours afte Funeral Dire		29a. Certifier 19 Cartifying Physic	ian: To the best of my knowle	edge, death	occurred at the time	e, date and place	, and due to the car	use(s) and manner	as stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Exemine one)	r: On the basis of examination and manner stated.	n and/or inv	restigation, in my op	inion, death occu	rred at the time, da	e and place, and du	ue to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	4.0		29c. License	number	29	d. Date signed (Mor	oth, Day, Year)
			SALSIE	ME		RIT-	000	\mathcal{A}	Whit K	2004
	2		30. Name and address of person who com	pleted cause of death (Item 2	3a) (Type.	Print)			yur!	1287
			BORFK, PETS,	Clower 110	1 11	HH 600	North	Wolfe	St. Pollin	une Md
Ŗ,	Sta	ite	31. Date filed (Moeth-Day) Year) 4	62 Registrar's Signatur	G	Long Val	,			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3Day 2004 **Physician** August 12:30 a M John Michael Fish /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1**X**]M 2□F Months Hours 51 Director 212-58-0764 12 1952 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow other traumatic avent. The Medical Examinary ust be notified at 1 AYes 2 No Director Maryland Baltimore n/a 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number United States 21230 1936 Deering Avenue or Itams 23a 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked othar than "natural", or Ital 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: \$ 3 ☐ Widowed 4 ➡ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fire Department 4 12 Captain 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Agnes Prime Rigby Earl W. Fish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 st partment of Health and cortant: If Item 27 Is n injury or other traur Earline Braatz / Sister 109 3rd Avenue, Brooklyn Park, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department Important: If any injury or Loudon Park Cemetery 8/11/2004 Baltimore, Maryland ' 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Minth Immediate Cause (Final disease or condition resulting in death) 16 Physician mu /Medical Due to (or as a consequence of) **Examiner** Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical the as IF FFMALE: esr. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 14 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1No 2 1 No 1 ☐ Yes 1□ Yes To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes/ 2 10 No 1 am patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation М 1 🔲 Yes 2 No 2 🗆 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day/Year) 29b. Signature and fitte of certific (np Heled cause of death (Item 23a) (Type-Print) 30. Name and address of pa molloin 22. Registrar's Signarui State Registrar

			For	State of Maryland / Dep	partment of Health and	-	_
			1 - State Registrar	Ce	ertificate of Death		9. Np. UUL 75545
П	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Yeer
	/Medic		Myrtle Virginia				10, 2004 7:15 A ^M
	Examir	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Deat	h	4c. County of Death
	•		1218 Washington 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Baltimore Will If Under 1 Year If Under 24 Hrs	8. Date of Birth	n/a 9. Birthplace (State or Foreign
	Funeral Director			M 2 KF 75 Yrs.	Months Days Hours Min.	(Month, Day,)	Year) 9. Birthplace (State of Poreign Country) 1928 Maryland
<u></u>			Usuel Residence of Decedent	7.5		Aug 24,	1926 Maryianu
	yland		10a. State 10b. County	10c. City, Town or			10d. Inside City Limits
	a-f e	tor	Maryland n/a	Baltimo	ore		1 1 Yes 2 □ No
	or 28	ire	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	23a	Funeral Director	1218 Washington		21230		nited States
	ams ams	nei	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	I. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or if	by Fi	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 □Yes 2 No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: White
Ö	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or liams 23e or 28e-f ehow event, I're Medical Examinat must be notified at	d be	15. Decedent's Educ	Year or Dates:	edent's Usual Occupation	16	6b. Kind of Business/Industry
Υ	n 72	olete	(Specify only highest grade	completed) (Giv	re kind of work done during most of wo . DO NOT use retired)	rking	bb. Kille of Besiliess/filedsity
12	filed withi Hygiene. ther than	Completed	Elementary/Secondary (0-12) 7	College (1-4or 5+)	ousewife		home
D	Hyg other	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	
au	should be nd Mental marked c	To B	Elmer Koethe		Annie 1	Naft	
ary	A DEE		19a. Informant's Name/Relationship (Typ	e, Print) 19b. Ma	iling Address (Street and Number or Re	ıral Route Number, (City or Town, State, Zip Code)
Σ	and 2 ealth a n 27 is		Albert L. Freeburg	er, Jr son 7830	Harbor Road, Pas	adena, Mar	yland 21122
ore	of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Disponental from State		ust 13,	c. Location - City or Town, State
Ĕ	Pages ment of l		* 4 ☐ Donation 5 ☐ Other (Specify)	Loudon F	Park Cemetery 2	004 Ba	altimore, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		21. Signature of Funeral Service License	nk 4	22. Name and Address of Facility Huild 107 Wilkens Avenue	obard Fune e, Baltimo	eral Home, Inc. ore, Maryland 21229
(F)	A lo		23a. Part 1. Enter the disease, pr complice shock, or heart failure. List only one				
	Physician		Immediate Cause (Final disease or condition	Phermania	\		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):			1 444
	Examiner		Sequentially list conditions. b.	Chronic O	bstructive Po	monary	Hiseage 104rs
120	Sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		1	9
	and I-tran	хаг	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
760,	ite be executed iysician and ne burial-transit	cal E					
687	ficate physis the		d.				
Box (certii nding use a	ZW.	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy	-		23d. Date of delivery
m	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
Ö.	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	9 Unknown	9☐ Unknown			
a, O	ss tha	by P	Part II. Other significant conditions cont	1	underlying cause given in Part I.		cco use contribute to the cause of death?
ord	equir en si ould b	fed	- Morbed or	esity		1 🗆 Yes	2 No 3 Probably 4 Unknown
ecc	law r as be	Completed	Heart ta	ilure		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u>س</u>	The ate h page	Con				performe 1 ☐ Yes 2 Œ	
/ita	cian: sertific actor,	Be	25. Was case referred to medical examiner?	enital		th (Check only one)	
of	Physi this c	L L	1 Yes 2 No	28a. Date of Injury 28b. Time		ome 5 Residence 28d. Describe how	te 6 Other (Specify)
Division of Vital Records,	ding la.	tion	1 ─Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		280. Describe now	injury occurred
S	deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s		28f. Location (Stree	et and Number or Rural Route Number,
2	ital or / irs after rai Dire	Certification:	4 Hollicide	building, etc. (Specify)		City or Town, S	
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examine	cian: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.	oth occurred at the time, date and place investigation, in my opinion, death occurred.	, and due to the caus rred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number	29d.	. Date signed (Month, Day, Year)
			1184		H0054337	Au	19.15, 2004
1	1		30. Name and address of person who are	ppleted cause of death (Item 23a) (Type	p, Print)	+ 1. L	NOODBINE
r			Dr. Kichard 3	32. Registrar's Signature	Apouls	uelt	ma 2/19/
3	Sta Registr		31. Date filed (Month, Day, Year)	Travers Signature	Sparker		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 10, 2004 12:15 JOSEPH F. FARACE, SR. /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE EASTPOINT NURSING HOME BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours 1**2** M 2 ☐ F 85 8/28/19 MARYLAND **Director** 220-07-1399 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rai', or itema 23a or 28a-i ahov Examiner must be notified at 1 ☐ Yes 2 No Director DUNDALK BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 123 BAYSIDE DRIVE USA Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MQYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: by WHITE 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Mudical 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) STEEL WORKER BETH STEEL other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be itam 27 is marked o ANNA LINNEMANN SAMUEL FARACE other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 BAYSIDE DRIVE BALTIMORE MD. 21222 MR & MRS.LEWIS KONOPACKI 20c. Location - City or Town, State SA GREEN cremation (Name of SA GREEN) cremation (Name of SE) 20a. Method of Disposition permit. Pages
Department of H
Important: If its
any injury or of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/12/04 MARY CEMETERY DUNDALK, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KACZOROWSKT TUNERAL HOME P.A. Casi DUNDALK AVE. BALTIMORE, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Nosclem **Physician** disease or condition resulting in death) /Medical Examiner ero SC Sequentially list conditions, Due to for as a consequence of n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year jo in the past 12 months?
1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No ithin 24 hours after death. the Funeral Director: All ompletely filled in by the fu death. investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my onicion, death occurred at the time. within 24 hours a 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier V 11150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 441 S. ELLWOOD AVE BALTO, MD 21224 M. TORNES, MD MELITO 32. Registrar's Signature Garles 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 1 3 2004

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** August 6, 2004 12:20 p M Josephine Gerardi /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1□ M 2□ F April 6, 1924 Director 060-18-2396 80 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County item 27 is marked other than "natural", or Itams 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at Forest Hill 1 ☐ Yes 2 No Md. Harford by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21050 1701 Rich Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) General Electric secretary 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi and Mental H Maria Passero Pietro Vergine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13801 York Road, Cockeysville, Md. 21030 Robert H. Dye/brother-in-law Department of Health Importent: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 8/9/2004 Baltimore, Md. Bayview Crematory any injury once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Furnia Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 4nd rome days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner halasia days peration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of use as the burial-tran Due to (or as a consequence of) Physician/Medicai ears menos anem IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Testal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions on tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation Director. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.X

Registrar

Jesophine V. Gerad

M800351417

Hartord Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

MD

32. Registrar's Signature

, SUN,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Russell David Gover Sr. August 2004 4:20a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6354 Barnett Avenue Carrol1 Sykesville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 26 1940 Birthplace (State or Foreign Country)
 Md 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 🕅 M 2 🗆 F 63 220-36-0302 Yrs. Aug Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County works ! 10d. Inside City Limits , or Items 23e or 28e-f shown in the rest of the state of Md Carroll Sykesville 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6354 Barnett Avenue 21784 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1969— If Yes, Give Year or Dates: 1970 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other then "neturel", or items other treumatic event, the Madical Extentions permil. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Item eny injury or other treumatic event, the Mulfal Exercitations. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) professional truck driver transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilmer Gover Lola Burke ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dotty Gover (spouse) 6354 Barnett Ave., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 8-16-04 Marriottsville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Herberst P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) melashahi small Cell Caccinona Physician 15 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Box 68760 Physiclan/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by obstructive pulmon, Area disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has 2 No 1 Yes To the Hospitel or Attending Physicien: director. 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification; 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hin 24 hours a 29a. Certifier 🖊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D3360 08/12/2004 (Jalua in 1 Trances k. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS GALVIN III MA 291 STOVER AVENUE WESTMINSTEIL MARYLANC 21157 31. Date filed (Month, Day, 3ar 2004 32 Registrar's Signature Registrar

Ronald E. Green Unpend item # 23a,27, per MR C835,9/9/04 TT State of Maryland / Department of Health and Mental Hygiene 04-05109 MAN 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 06, 2004 6:05 PM Green Donald EARI /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/a 2525 E. Biddle Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□F Months Days Hours Min. Yrs. 218 66 230 Director August 22,195 Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or flems 23e or 28e-f show any injury or other treumatic event. The Madical Exuminations is notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 □ No Completed by Funeral Director DA HIMURE MI 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2525 Street 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ze No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Danitotion DEpartment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EARL Mangaret 2 Kubert GLEEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2525 21213 BiddlE. BAHAMUS MD Margaret Berns 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HRBULUS MEMORIAL * 4 ☐ Donation 5 ☐ Other (Specify) 104 LA HIMUR MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DEHS Funeral ature Deleto BALLIMORS MD 21213 1 1129 N. CARGLINE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Renal Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760 by Physician/Medical as the attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2XNo 1 TYes Division of Vital To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) At scene XXYes 2 □ No 2 within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier August 07, 2004 O.C.M.E. Mprite 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREL MARYD BUT 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

2004

32. Registrar's Signature

AN	GALLEG	OS	AMEND ITEM #1	PER ME C	335 (Iryjan	7/02/0	irtmen	t of H	ealth a	and M	lental Hy	gien	e	ic.		
			1- For Amend Item Registrar AMEND ITEM	o per FH,G 206 PER F E	834, 1334	08/13/ .8/7 ₹	Of Call	of L	Death			Reg. N	200	4	255	51
	Physici	an	1. Decedent's Name (First, Middle, Las	()	1000	O LS 	UT UI	_			2. Date of De Month		ay \	ear e	3. Time of	Death
	/Medic		J aun Gallego s	JUAN GALI	LEGOS	5					AUG.		2004		5:30	A M
	Examin	er	4a. Facility Name (If not institution, give		ו או או או אויי	DOVD		10wn, or XKVI	Location o	of Death			c. County of		v	
	Funeral		OUTERLOOP 495 @ 5. Social Security Number Unk 6. St			last birthday)	If Under	1 Year	If Under		8. Date of Bir			9. Birthp	lace (State o	r Foreign
	Director		N/A UIR 1	⊠M 2□F	49	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Pa	955	7)	Ecu	ador	
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							1	0d. Inside Ci	tv Limits
	Maryl f eho	tor	Ct Fairfi	eld		amford									1 ▼ Yes	-
	r 28e	irec	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wh	at Cour	ntry?	
	th with	ai D	145 Frederick St	reet			C	06902	2			E	cuado	r		
	tome	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.))-	14. Race Black,	Americ White,		
36	rs afte	by F	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 🖾 N If Yes, Give Year or Dates:	10		t x Yes 2	2□ No	Specify:				Specify:]	lisp	anic	
21215-0036	72 hours after deeth with the Maryland Insturat; or iteme 23s or 28e-f ehow disal Examilier meat be molified at	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usua	I Occupa	ition			16b.	Kind of Busi	ness/Inc	dustry	-
218	withIn 7 ene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+)	lite.	kind of wor DO NOT us	se retired)	uring mosi	t or worki	ng					
	filed with Hygien Sther the		12	8		Eng	ineer		10 Mothe	de Nemer	(Final Adiabath		1f Em		ed	
anc	d be find he of ot	Be c	17. Father's Name (First, Middle, Last) Bolivar Gallegos								<i>(First, Middl</i> e, errera	, Malde	п Зитате,			
Maryland	2 should and Me is mark aumati	ဥ	19a. Informant's Name/Relationship (7						nd Numbe	or Or Rura	I Route Numb					
	iges 1 and 2 should be filed within 72 hours after deeth with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23s or 28e-f show or other traumatic event, the Madical Examinar missible in odiffied at		Isabel Gallegos/	Wife		145 F	reder	ick	Stree	et Si	tamford	Со	nnect	icut	06902	2
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Bernoval from State	20b. P	lace of Dispo emetery, crer	sition (Nan matory or o	ne of ther place	9)	8/13	70 4	20c.	Location - C	ty or To	wn, State	
ţi Ţ	Pag tment tant:		*4 □ Donation 5 □ Other (Specify)	Gar	dens S			1		704		rth Be			- 1
Ba	permit. Pages. Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licen	\$00							o F. Ga . Stanf		_			eral
l.			23a. Part . Emer the disease, or complete hook, or heart failure. List only	olications that caused one cause on each lin	the death	n. Do not ent	er the mode	e of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a NECK IN	SULLE	s and	campi	estici	JAL 1	Asph	TXIÀ				Onset and I	Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	uence of):				4						
	1 6 3	ler	Sequentially list conditions, it any leading to immediate	b. Due to (or as a	a consequ	uence of):										
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
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6876	physic physic the b	.0		. d												
9 XC	death certificate e attending phys d for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date	of delive	IV.	
Вох	death e atter d for u	iciar	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pro Other (sp						Month			'ear
P.0		hys	9 🗆 Unknown	9□ Unknown												
Ś	Se G es	by	Part II. Dther significent conditions of	ontributing to death bu	ıt not resi	ulting in the u	nderlying ca	ause give	n in Part I.				V		e cause of d ably 4 □L	
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Vital	iclan: T	0	25. Was case referred to medical						26 Place	of Death	(Check only o	2 N	0 12	Yes	2□ No	
Ţ		To B	examiner? 1 XYes 2 □ No	Hospital: 1 Inpatie	nt 2 🗆	ER/Outpatien	t 3 DO	A Cthe			ne 5□Resid		6 X Other	(Specify	AT S	CENE
n of	Ing Pt		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur	Year)	28b. Time of Injury		8c. Injury Work	at ?		28d. Describe I		1 .			
Sio	tend death for: /	icat	2 Accident investigation 3 Suicide 6 Could not be	CHUCK	At bo		A M	1 🗆 Y	es 2501		MOTOY (15161	Courte Mum	har
Division	or A efter Direct In by	Certification:	4 ☐ Homicide determined	building, etc	. (Specify	Hishwa		, опісе			City or Tov	vn, Sta	10) outer	leep a	195, wes	+
	To the Hospital or Attending Phys within 24 hours eiter death. To the Funerel Director: After this completely filled in by the funeral di	edicai C		ysician: To the best of niner: On the basis of		wledge, death	occurred :			d place, a	and due to the	cause(s) and mann	er as st		
	the H hin 24 the F nplete	Medi	one)	and manner sta	ted.			. License		ar occurre						
1	To To		29b. Signature and title of certifier	111	L		290		.M.E				ate signed (: AUG •		2004	
	. 1		30, Name and address of person who	completed cause of de	ath (Item	23a) (Type	Print)									
	10		PAMELA E. SCUTH	II. M.D.				eet,	Balt	imor	e, Mary	ylar	nd 212	01		
	Sta		31. Date filed (Month, Day, Year) AUG 1 3 2004	32. Registra	ar's Signa	19 1	pork	21								
	Registr	ar	AUG I 3 ZUU4	1		- 19		~								

	4 Cana	epartment of Health and Mental H	-
Physician /Medical Examiner	Howard E. Hesterberg	2. Date of D Month TVGU 4b. City, Town, or Location of Death	Peath 3 Time of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birth. 215-09-4058 88 Yr Usual Residence of Decedent	Months Days Hours Min. (Month, D	irth (2007) 9. Birthplace (State or Foreign (2007) 10,1916 Maryland
he Maryland 88a-f ehow	10a. State 10b. County 10c. City, Town of	imore	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
th with the Case of Sas	10e. Street and Number 4200 Hooper Avenue	10f. Zip Code 21229	10g. Citizen of What Country? United States
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examina traumatic event, the Medical Examina traumatic event, the Medical Examina traumatic rectified at To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	o- 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036 ed within 72 hours atl ygiene ier than "natural", or t, the Medical Exert	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Bive kind of work done during most of working fe. DO NOT use retired)	16b. Kind of Business/Industry
Maryland 2: td 2 should be filed v th and Mental Hygie t7 le marked other t traumatic event, in	17. Father's Name (First, Middle, Last)	esman 18. Mother's Name (First, Middle Gertrude Romans	
≥ 5€7.	19a. Informant's Name/Relationship (Type, Print)	lailing Address (Street and Number or Rural Route Numb 5 Grandview Road, Hanover,	per, City or Town, State, Zip Code) Pennsylvania 17331
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 27 1 any injury or other tre	20a. Method of Disposition 1 Paparial 2 Cremation 3 Removal from State	Park Cemetery 22. Name and Address of Facility Hubbard Fu	20c. Location - City or Town, State Baltimore, Maryland
Physician /Medical	23a. Part1. Enter the disease or complications that caused the death. Do not shock, or heart failure Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	4107 Wilkens Avenue, Balt	imore. Maryland 21229
Examiner 5	d	Lenal Failure	2 weeks
Box Box leath cert attending for use or	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
ds, P. ds, P. uires that the signed by lid be detacted by Phy			obacco use contribute to the cause of death? Yes 2 12/2 No 3 Probably 4 Unknown
The atten page		AC 24a. Was autor perfo	an 24b. Were autopsy findings available prior to completion of cause of death?
HOWOLD II Division of Vita Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification; To Be C	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injure	of 28c. Injury at 28d. Describe t	
HOUCLY Division of Division of Attending Parts and Geriffert affect affect affect affect in by the funeral Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	City or Tov	
the Hospi in 24 hour the Funer pletely fill edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	021649	29d. Date signed (Month, Day, Year) AUGUST 13, 2004
State	30. Name and address of person who completed cause of death (Item 23a) (Typ. SANSAW) AN BASICAL 3 455 31. Date filed (Month, Day, Year) 32. Registrar's Signature	WILKERN AVE BALTIM	INF, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, **Physician** 0615AM /Medical 4c. County of Death Facility Name (If not institution, give street and number 4b City Town or Location of Death Examiner Samaritan BAITMORE If Under 24 Hrs. Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Days 1 MM 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10h County 10a State 10d. Inside City Limits Show other treumstic event, It a Medical Exacting trust be notified at 1XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code or Items 23a Funerai Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should ba filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neture!", any Injury or other treumatic avent Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NO<u>I</u> use retired) 15. Decedent's Education 16b. Kind of Business/Industry only highest grade completed) College (1-4or 5+) 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, BU to. MD2/2/8 Date. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COrono **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 2 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes Hospital: Other: 2 No 1 Impatient P 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending within 24 hours after death, To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

Kenneth

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven 13/Vd., Baltimore, MD 21239

D 25527

			1- For Amend Item #1 State of Maryland / Department of Health and M Certificate of Death			1	Physical Colonial I
1			1. Decedent's Name (First, Middle, Last)	2. Date of Deat		- I	3. Time of Death
	Physici /Medio		CHARLES McLANE HAYNIE, SR.	Month August	9,2004	Year	7:05 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mariner Health and Rehabilitation Laurel		Anne A		101
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,			ace (State or Foreign try)
н	Director		213-01-7014 1型M 2□F 86 Yrs. Months Days Hours Min.	Month, Day, May 13	, 1918		vland
	and		Usual Residence of Decedent 10a. State 10b. County Prince Georgeo. City, Town or Location			10	Od. Inside City Limits
	Maryl I aho	ţō	Maryland -Anne Arundel Laurel				1 ☐ Yes 2 ☑ No
	th the	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of W		try?
	s 23a	ral	9000 Briarcroft Lane Apt. 239 20708		USA		
980	s I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Examili at most be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Maried 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ N	ecity Yes or No- Rican, etc.)		- America , White, e	
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	filed y Hygie other ent, tr	a	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M			
/lan	uld be Mental Irked	To B	Clarence Samuel Haynie Sadie	Abbott	-		
Maryland	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura				
	1 and Health em 27 ther t			-	20c. Location - C		
Baltimore,	t. Page rtment o rtant: If njury or		1 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Cedar Hill Cemetery 8/12	/2004	Baltimo	re, l	Maryland
Bal	Departiment of the control of the co		21. Signature of Funeral Service Licensee Kevin E Ecker McCully—Polyniak Fi 237 E, Patapsco Av	e., Balt	o.,Md.	A. 212	25-1856
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
ı	Examiner		Discobacio				
	D =	iner	Sequentially list conditions, if any, leading to immediate chart. First 11 serior. Cause (Disease or injury				-
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			_	
68760,	s be ex		d				
	tificate ig phys as the	ledicai	0.				Wall to the control of
Вох	attending for use a	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date Mont		1
	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burral-transit	Physician/M	1 Pres 2 No 9 Unknown Unknow		Widne		Day Year
P.O	res that tigned by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contrib	oute to the	a cause of death?
rds	w requires been sign should be	ed by	Alzheimers Disease	1 □ Ye	s 2 No 3	☐ Proba	bly 4 □Unknown
Vital Records,	has bei	Completed		24a. Was an	/ pri	or to com	sy findings available pletion of cause of
E R	ilcian: The certificate hi rector, page	Co		perform 1 Yes 2	ied? de	ath?	No
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of	ig Phys ter this heral di		27. Manner of Death 28a. Date of Death 28b. Time of 28c. Injury at 2	ne 5 Resider 28d. Describe hor			
ion	별으호기	atio	2 Accident investigation M 1 Yes 2 No				
Division	or Atta	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str. City or Town,		or Rural	Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a '2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	use(s) and mannete and place, an	ner as stat d due to t	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier / / . 29c. License number		d. Date signed (
	0-0		Many fell 005323	5 14	ugust	10,	2004
1	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Darry Hill 13635 Balt, more Ave	- 60	urel	p	10
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 \$ 2004 22. Registrar's Signature				

			1 - For State Registrar	State of	Marylar		artment rtificate			and M	ental Hyg	iene eg. Nø.	004	25555
	Discontinu		1. Decedent's Name (First, Middle,	Last)							2. Date of Deat	th	Year	3. Time of Death
	Physici /Medio		Donna	Johns	son	Ha	aden				July 29,	2004	4	10:22 P M
	Examir		4a. Facility Name (If not institution, g				4b. City, To			f Death			ounty of Dea	
			554 Wilson Brid	ge Drive	Apt I	31	0xon					Pri	nce Ge	eorge's
	Funeral Director		145-34-7874	Sex 1□ M XXX	7. Age (In yrs. 6]	last birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min,	8. Date of Birth (Month, Oay, 03/26/1	943	9. Bir Co New	thplace (State or Foreign ountry) Jersey
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	e Maryli ta-f sho	ctor	Maryland Prince	George's		on Hil								1 □ Yes 🏋 🗓 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mental Hyglene. Department of Heatih and Mental Hyglene. In the more stated of the then "leturel", or Items 23a or 28a-f show my highly or other treumatic event, the Medical Examinating results and Item of Items. DDCs.	Funeral Director	10e. Street and Number 554 Wilson Brid	ge Drive	Apt.	B1	10f. Zip C		745		1	0g. Citizer US <i>I</i>	n of What Co	ountry?
	ms 2	ner	11. Marital Status	12. Was Deced		J.S. 13.	Was Deceder	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14.		erican Indian,
9	or Ite	Ī	1 ☐ Never Married 2 Married	Armed Ford	2₹ No					, Риепо н	Hican, etc.)		Black, Whit	e, etc.
03	rel'.	l by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2X	W 40	Specify:			Sp	ecify: Wh	ite
2-0	72 hc	Completed	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual (Occupat	ion	of workin	na .	16b. Kind	of Business	/Industry
21	thin en *	nple	Elementary/Secondary (0-12)	2 College (1-	4or 5+)		kind of work DO NOT use				, g			
21	od wi	Sol				Medic	al Tec	hno.	logis	t		Heal	thcar	е
nd	2 should be filed within and Mental Hygiene. Is marked other ther eumatic event, It e Mental Hygiene.	Be	17. Father's Name (First, Middle, La					1	18. Mothe	r's Name	(First, Middle, M	Maiden Su	mame)	
yla	Ment Ment arke	2	Donald Johns	on 							Johnso			
Maryland 21215-0036	and and ls my		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (S	Street ar	nd Numbe	r or Rura	l Route Number,	City or To	wn, State, 2	Zip Code)
	1 and Health Iem 27 other tr		James D. Haden J	r. / Hust					lge I			xon F	Iill,	MD 20745
Baltimore,	of Her		20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Removal from S		Place of Dispo cemetery, crea	sition (Name natory or othe	of er place))	D	ate	20c. Locat	ion - City or	Town, State
Ĕ	Pag nent ent: I		4 □Donation 5 □Other (Spe		Ar1	ington	Nat.	Cem.	. 0	8/17	/2004	Arlin	gton.	Virginia
att	permit. Pages Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Service Lic	ensge		22	. Name and	Address	of Facility	Ka1	as Fune	ral E	lome P	. A .
m	89 2 2 3		11. Ja	las /		61	60 0xo	n Hi	i11 R	oad	Oxon Hi	11. M	larv1a	nd 20745
			23a. Page. Enter the disease, or co shock, or heart failure. List on	mplications hat ca	used the deat								,,,,,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	.,	CAN	Je SATA	15 /1	20	17	Gai	TINE			Onset and Death
	/Medical		resulting in death)	a Due to (o	r as a consec	bence of):	0 14		<u> </u>					grid
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (d	r as a consec	quence of):								
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c										
ó	an ar	EX	resulting in death) Last	Due to (o	r as a conseq	(uence of):								
8760,	ate be nysici ne bu	edical		d										
99	ng ph as ti	Med	IF FEMALE:											
XO	eath certific attending p	an/h	23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 Feta		Ectopic pregi	nancv				23d.	Date of deli	
Ö.	dea od fo	slci	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (speci						Month	Day Year
P.0	at the de I by the stached	Physician/M	9 Unknown											
Records,	The law requires that the death certificate be executed tee has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditions	contributing to dea	ith but not res	sulting in the u	nderlying caus	se given	in Part I.		23e. Did tob	~/		the cause of death?
00	w requir been si should I	Completed									24a. Was an	2	th Ware au	topsy findings available
Re	The tay cate has page 2	E D									autopsy	,	prior to d	completion of cause of
		e Co	OF Was ones referred to modical									ØNo	1 🗆 Yes	2□ No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 4e	Hospital:	patient 2 🗆	ER/Outpatien		Other:			(Check only one			
of		—	27. Manner of Death	28a. Date of		28b. Time of			4 1901	sing Hom	ne 5 A Pesider 8d. Describe hov			city)
on	ding I th. After funer	tior	1X2Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury	М	Injury a Work?	s 2∐N			,,		
Division	or Attending after death. Director: After In by the fune	fica	3 Suicide 6 Could not	be 28e. Place o	f Injury - At he	ome, farm, str	eet, factory, o				8f. Location (Str.	eet and No	ımber or Ru	ral Route Number,
=	s after s after el Dire ed in b	Certification;	4 Homicide	building	, etc. (Specif	y)					City or Town,	State)		
	To the Hospitel or within 24 hours after To the Funerel Directory completely filled in E	edical	29a. Certifier XX Certifying 2 Medical Ex	Physician: To the basaminer: On the bas and manne	is of examina	wiedge, death tion and/or inv	occurred at t restigation, in	he time, my opir	, date and nion, death	place, a	nd due to the ca d at the time, da	use(s) and te and pla	l manner as ce, and due	stated. to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	R			29c. L	icense r	number		29	d. Date sig	gned (Month	n, Day, Year)
			•	I)19	147	j		7/3	104	
	12		30. Name and address of person w	o completed cause	of death (Iten	n 23a) (Type,	Print)		13/			-/-	-1 - 1	
	10.		Frank M. Ryan	MD 11	701 Li	vingst	on Road	1_#	203	Ft. V	Washingt	on.	Marv1a	and 20744
	Sta * Registr	1 3	31. Date filed (Month, Day, Year) AUG 1 3 2004		gistrar's Signa	iture	backs							

			1 - For State of Maryland / Department of Healt Certificate of Dea		ygiene Reg. No2 0 0 4 2 5 5 5 6
	Physici			2. Date of D	Peath 3. Time of Death 3. Time of Peath 3. Time of Peath 3. Time of Death
	/Medic Examir				4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 Months Days Hou 6. Sex 1 Months Days Hou	nder 24 Hrs. 8. Date of B	Pay, Year) Country)
	the Maryland 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Ballimuke 10e. Street and Number 10f. Zip Code		10d. Inside City Limits 10f. Pres 2 □ No 10g. Citizen of What Country?
36	i 72 hours after deeth with the Maryland "natural", or frema 23a or 28a-f show sdical Examinat must be molliked at	by Funeral DI	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		U.S.A.
21215-0036	within 72 hour. ene. than "natural" the Medicul Ex.	Completed b	Tear or Dates:	most of working	16b. Kind of Business/Industry
Maryland 21	be filed ntal Hygi od other event, t	To Be Col	17. Father's Name (First, Middle, Last)	Nother's Name (First, Middle) Violo Wil	
	Tand 2 sh Health and tam 27 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Null Self-bit) 19b. Mailing Address (Street and Null Self-bit) 19b. Mailing Address (Street and Null Self-bit) 20a. Method of Disposition 20b. Place of Disposition (Name of	0	Der, City or Town, State, Zip Code) 3.05 2.c. Location - City or Town, State
Baltimore,	permit. Pages Department of Important: If i any injury or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Advess of Fa	4	
*	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS SIN DRONE		
8760/	Medical Examiner hysicien and the burial-transit	Ilcal Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ciscase of migury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
P.O. Box 68	ath certific attending p	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
	w requires that the de been signed by the a should be detached to	by	Part II. Dities significant conditions continuous to death but not resulting in the underlying cause given in Pa		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 riknown
Vital Records,	The ate h page	Completed		24a. Was auto perfo 1 □ Yes	
of	Attending Physicien: Thir death. •ctor: After this certificate by the funeral director, pag	atlon; To Be	examiner? 1 Yes 2 You	28d. Describe	one) idence 6 □Other (Specify) how injury occurred
Division	i i i i i	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Rural Route Number, wn, State)
	he Hospital in 24 hours a he Funeret I pletely filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date of the basis of examination and/or investigation, in my opinion, of and manner stated.	e and place, and due to the death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	vithin 2 To the complete	×	29b. Signature and title of certifier 29c. License number 29c. License number	L634	29d. Date signed (Month, Day, Year) AUGUST 9, 2004 NE, AD 21202
	φ		0.	= BALTIMO	RE, AD ZIZOZ
	Sta Registi	_			

		•	1 - For State Registrar		Department of Health and Certificate of Death	Mental Hygier	2001	25557
	Physici		Decedent's Name (First, Middle, Last) VORY MINTHA			2. Date of Death Month	Day Yeer 2004	3. Time of Death 1 2:32 P M
	/Medio Examin		4a. Facility Name (If not institution, give the MORL)	street and number) AL HOSPITAL	4b. City, Town, or Location of De BALTIMORE	ath	4c. County of Death	A
	Funeral Director		5. Social Security Number 6. Ser 213 · 30 · 4232	Tu side	thday) If Under 1 Year If Under 24 H Yrs. Months Days Hours Mi		9. Birth Cou	nplace (State or Foreign untry)
	ith the Maryland or 28a-f show	tor	10a. State 10b. County	10c. City, Town				10d. Inside City Limits 1 Yes 2 □ No
	with the	i Direc	10e. Street and Number 2119 CYLBURN	AVENILE	10f. Zip Code	10g. (Citizen of What Cou	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f ahow important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f ahow any injury or other traumatic event, the Medical Examinar ruled the multiple at once.	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes. 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 Yes 2 No Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Amer Black, White	
21215-0036	within 72 ho one. than *natur ne Medical	Completed	15. Decedent's Edu (Specify only highest grade	completed)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking	Kind of Business/le	ndustry CARE
Maryland 2	should be filed with nd Mental Hygiene i marked other tha imatic event, tha	To Be Co	17. Father's Name (First, Middle, Last) WILLIE JACKSON	J		ame (First, Middle, Maid	en Sumame)	CHILL
	1 and 2 sho Health and heem 27 is ma		19a. Informant's Name/Relationship (Ty JAMES HENDE 20a. Method of Disposition	ERSON 20	Mailing Address (Street and Number or I	BALTO.	y or Town, State, Zi	1215
Baltimore,	permit. Pages Department of t Importent: If It eny injury or o once.		1	KING	. 22. Name and Address of Facility		NDALIST SERVICE	
4	Physician		shock, or heart failure. List only or Immediate Cause (Final	ications that caused the death. Do not cause on each line.	551 BAVO. NATE From the mode of dying, such as cardial Cardia Mun.		SERVICE MO 212	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Renal Fa		pang		UNKNOWN
9	icate be executed physician and s the burial-transit	ai Examiner	Sequentially set nonctitors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (* as a consequence of Due to (* as a consequence of	lemia			UNKNOWN
P.O. Box 68769	death certif e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliv	very Day Year
	sign d be	þ	Part II. Other significant conditions con	ntributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco	- \	the cause of death?
of Vital Records,	: The law requirate has been page 2 should	Completed				24a. Was an autopsy performed 1 Yes 2011	prior to co	opsy findings available ompletion of cause of
Vita	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital: 1 Anpatient 2 ☐ ER/Ou	Othac	eath (Check only one) Home 5 Residence	€ □Other (See	(6.1)
	fune fune		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury 28b. T	Fine of njury at Work? M 1 Yes 2 No	28d. Describe how in		<i>y</i> y
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street City or Town, Sta	ite)	
	To the Hospital within 24 hours of To the Funeral completely filled	edical	29a. Certifier Certifying Physics (Check only one)	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	e, death occurred at the time, date and pla d/or investigation, in my opinion, death oc-	ce, and due to the cause curred at the time, date a	s) and manner as s nd place, and due t	stated. to the cause(s)
•	To the within to the comp	Ž	29b. Signature and title of certifier	werm, r	29c. License number AT243894	11-1520 /	Pate signed (Month, Hug - 08	Day, Year) 2004
	4		30. Name and address of person who co	completed cause of death (Item 23a) ((Type, Print) UNION ME 201 E. UNIV	EMORIAL PKI	HOSP JA	I IMD
	Sta Regist		31. Date filed (Month, Pay Year) 004	32. Registraris Signature	Sparks	•		21218

			1 - For State Registrar	State of Marylan		artment of F tificate of		nd Menta	l Hygiei Reg.	2001	25558	
	Physic /Medi		1. Decedent's Name (First, Middle, Las Samuel	Mc Mc						e of Death nth Day Year Qust 7, 2004 1457 p. 16		
	Exami		4a. Facility Name (If not institution, give Johns Hopkins Ho			4b. City, Town, o Balti				4c. County of Deat		
	Funeral Director		5. Social Security Number 6. Se 091-44-1728 Usual Residence of Decedent	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mor	of Birth oth, Day, Yes -8-52	ar) 9. Birt	hplace (State or Foreign untry) S.C.	
	death with the Maryland ms 23e or 28a-f show	tor	10a. State 10b. County		, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	h with the 38 or 28s	Funeral Director	10e. Street and Number 429 E. Lafayett		Dalcin	10f. Zip Code	202		10g.	Citizen of What Co	untry?	
336	or ite	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1. Yes 2 □ No If Yes, Give Year or Dates:	11	Vas Decedent of H Yes, specify Cuba		? (Specify Yes uerto Rican, e	or No-	14. Race - Ame Black, White		
21215-0036	n 72 ho "natur	Completed	15. Decedent's Edd (Specify only highest grad	College (1-4or 5+)	(Give life. [ent's Usual Occupi kind of work done of OO NOT use retired	ation during most of	working	16b.	Kind of Business/		
land 2	be filed Ital Hygi od other event, I	To Be Co	12th grade 17. Father's Name (First, Middle, Last) Robert	4 yrs.		ilitary		Name (First, A	Middle, Maid	Air Ford Fickli		
Maryland	s 1 and 2 should be Health and Mental Item 27 is marked o other treumatic ev	1	19a. Informant's Name/Relationship (T) Flossie Holmes		19b. Mailin	g Address (Street a	and Number o	r Rural Route I		y or Town, State, Z	ip Code)	
Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition **Seurial 2 Cremation 3 F **4 Contains 5 Other (Specify)	20b. Pl	ace of Dispos metery, crem	sition (Name of atory or other place) Forest V	θ)	Date Date	20c.	Location - City or I wings Mil	Town, State	
Balti	permit. Page Department of Importent: If any injury or once.		21. Agnature of Funeral Service Licens		22.	Name and Addres	s of Facility	Bal	timor		21202	
68760,	hysician and hysician and street be executed with the private in the burial-transit	edical Examiner	23a. Fh.11. Enter the disease, or complete, or heart failure. List only of limit eliate Cause (Final disale or condition returning in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liease of the young that initiated events resulting in death) Last	ications that caused the learning cause on each line. a	ence of):	r the mode of dying	g, such as car	diac or respiral	tory arrest,		Approximate Interval Between Onset and Death	
.O. Box	t the death certif by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of dea 4 □ Pregnant at time of dea 9 □ Unknown	death 3⊡6	Ectopic pregnancy Other (specify)				23d. Date of delive	ery Day Year	
Records, P	w requires that been signed I should be det	by	Part II. Other significant conditions cor						Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
_		e Completed	25. Was case referred to medical							prior to co	opsy findings available impletion of cause of	
Division of Vi	ng Phys fter this ineral dii	Certification: To Be	examiner?	(Month, Day Year)	28b. Time of Injury		4 Nursin	28d. Desc	Residence ribe how inju	6 □Other (Special		
Div	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City o	r Town, Stai	,		
	To the Hos	Medical	one)	sician: To the best of my knowner: On the basis of examination and manner stated.	ledge, death on and/or inve	stigation, in my opi	nion, death o	ace, and due to courred at the to	ime, date an	nd place, and due to	the cause(s)	
)	T W T		29b. Signature and title of certifier	-Polle	MD	29c. License OCME	number			ate signed (Month, ust 8, 20		
4				vica-tollak	MI	111 Pen	n Stre	et, Bal	timor	e, Maryla	and 21201	
	Sta Registr	_	31. Date filed (Month, Day, Year) ALIG 1 3 2004	32. Registrar's Signatu	re							

			State of Maryland / Department of Health and Me	ental Hygier	ne NOOL OFFE
			Registrar Certificate of Death	Reg. A	(o.) () () () () () () () () () (
I	Physicia /Medic	an	HEIRY HAIRSTON	Month E	2004 7:15 PM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4	Ic. County of Death
	Funeral			8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director	4	239-07-1999	VOUTEMBER	227,19/2 NC
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	a-f sho	ctor	MD N/A Baltimore		Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marchal Ever, it at must be notified at once.	Completed by Funeral Director	10e-Street and Number 10f. Zip Code 2/2/7	7 10g. C	Citizen of What Country?
9	after deal	Funer	11. Maritel Status 12. Was Decedent Ever in U.S. Armed Forces 12. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto R 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No	city Yes or No- tican, etc.)	14. Race - American Indian, Black, White, etc.
-003	hours tural',	ed by	3 d Widowed 4 □ Divorced Year or Dales: 15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Specify: Kind of Business/Industry
215	thin 72 e. en "na	npiet	(Specify only highest grade completed) (Give kind of work done during most of working life. DONOTUSE retired) Elementary/Segondary (0-12) College (1-4or 5+)	9	- 1
121	filed with Hygiene. other than	Con	17. Father's Name (First, Middle, Last)	(First, Middle, Maide	and a CCO
Maryland 21215-0036	should be f nd Menta? I marked of umatic evel	To Be	KOBERT HAIRITON Phos	SIA É	logee
	and 2 sho ealth and n 27 Is m		19a. Informant's Name/Relationship (Type, Print) 19 Mailing Address (Street and Number or Rural) 19 Mailing Address (Street and Number or Rural)	Ball	Tud 21217
Baltimore,	permit. Pages 1 and: Department of Health Important: If item 27 any injury or other tr onca.		20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 2 2 2 2 3 4 4 2 4 4 5 5 5 5 5 5 5 5	20c.	Location - City or Town, State
Balti	permit. Departn Imports any inju		21. Signature of Funefal Service Licensie 22. Name and Address of Facility 11	Wells	Juneal Hom
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCANDIAL IT	YFARC	Onset and Death
	Examiner		Due to (or as a consequence of):		
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
_	ficate be executed physician and is the burial-transit	Examiner	c. C. Due to (or as a consequence of):		
6876 0 ,	te be e ysician e buris	dical	d		
-	intificating physes as the	w I			
Вох	eath certif attending for use a	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
P.O.	the de	hysic	1 Yes 2 No 9 Unknown 9 Unknown		
	law requires that the death certif as been signed by the attending 2 should be detached for use a	by	Part II. Other significant conditions contributing to death out not resulting in the didentitying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ecords,	aw require as been si 2 should b	Completed	- DEMENTIA - URINARYTRACT INFECTION	24a. Was an	24b. Were autopsy findings available
α	The ate h	Com		autopsy performed? 1 Yes 2	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		
of	S S	: To	1 Inpatient 25 Proupatient 3 DOA 4 Nursing Hom	1e 5 Residence 8d. Describe how in:	6 ☐Other (Specify) jury occurred
ion	Attending r death. ector: After by the fune	atior	Description (Month, Day Year) Injury Work? 2 Accident investigation M 1 ☐ Yes 2 ☐ No		
Division	al or Atte	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C			
	To th within To th compl	Me	29b. Si nature and title of certifier 29c. License number		Date signed (Month, Day, Year)
)					3-11-2004
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M'L. Dochhaker 300 AR MORY PL	ACES	3AL, MD
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
	Regist	ar	AUG 1 3 2004 Marine 15 Course 2		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ng. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Dea Dey Year **Physician** 08 2004 HARRIS SHIVZLEY 0 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number 4c. County of Deeth Examiner Andallstown 40 Baltimare a 6. Sex 8. Date of Birth NOV. 16, 1925 If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last bigthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 ▼ F Months Hours Yrs. 2/2:222260 Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo BALTIMORE MD PIKESVILLE 10e. Street end Number 10f. Zio Code 10g. Citizen of What Country? 3 STONEHENGE CIRCLE #8 21208 USA by Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. iled within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked FRIEDLANDER LENA (UNKNOWN) ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 STONEHENGE CIRCLE #8 - PIKESVILLE, MD 21208 STANLEY HARRIS / HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 8/12/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) a SUPTIC SHOCK HOURS Examiner Due to (or es a consequence of): Physician/Medical Examiner 2-3 DAYS INTRAPPOSITION CATASTROPHE attending physician and for use as the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or as e consequence of): 68760. Due to (or as a consequence of) signed by the a Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎝 Unknown Sevence affer death. I Director: After this cardificate has been signed by the control of the control o þ Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? ATTILAZ F1374W5700 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 1 Yes 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by tha 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗆 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

21

MD

32. Registrar's Signature

FRA

AUG 1 3 2004

31. Dete filed (Month, Day, Yeer)

CROSSROADS DZINE #360 : QUING MILLS, MD 7/117

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Ray 6/95

State Registrar

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		1 - State Registrar			Certi	ficate of	Death	1		Reg. No.	104	25561
Physici	an	Decedent's Name (First, Middle ROBER		JOSEPH,	JR.				2. Date of De	t 2 ^{Day} 2	OO4 ^{Year}	3. Time of Death 08:50 A.
/Medic Examir		4a. Facility Name (If not institution Johns Hopkins	n, give street and number			b. City, Town, o		of Death			unty of Dea	
Funeral Director		5. Social Security Number 212–13–0748		age (In yrs. last bir 19		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Month, D 5/26/1	rth (Year) 985	9. Bir MAR	thplace (State or Foreignatry) YLAND
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City, Town		ion IMORE C	TTY					10d. Inside City Limit
with the	Director	10e. Street and Number 931 WEBB CT.				10f. Zip Code 212	202			10g. Citizen	of What Co	ountry?
urs after death al', or Items 23	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	If Yas Giva			s Decedent of Hes, specify Cuba			ecify Yes or No Rican, etc.)	0- 14.		
Definition (e.) What yield a filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Separtment of Health and Mental Hygiene. By Appropriant: If item 27 is marked other than "natural", or Items 23a or 28a-f show may injury or other traumatic event its Medical Eventinating colline 1 at 2008.	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 1 1 TH	it's Education st grade completed) College (1-4or		(Give kir life. DC	nt's Usual Occup of of work done NOT use retired	during mos d)	st of work	sing		of Business TIMOR	/Industry E CITY
y latter vould be file if Mental Hy narked oth natic even!	To Be		TWAN JOSEPH,				JC	CELY		NLEY		
C, IVICAL thand 2 sh Health and fem 27 is n wither traun		19a. Informant's Name/Relations JOCELYN STANLEY		93	31 WE	Address (Street		IMOF	RE, MD	21202		
permit. Pages 1 and 2 should Department of Health and Man Important: If tem 27 is marke any injury or other traumatic.		20a. Method of Disposition XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	e KING M	ry, crema ÆM •	PK • CEM		8/11		RANDA	LLSTO	Town, State
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	1.1	any	460	lame and Addre	TY HE	EIGHT	S AVEN	JE, BA		21207 RE, MD
Physician /Medical Examiner		23a. Put Effer the decase, or shock, or heart trilure. List Immedate Cause (Final disease or condition resulting in death)	_a_ Mu	ed the de th. Do i	9h	the mode of dying the state of				arrest,		Approximate Interval Between Onset and Death
e executed ian and urial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	s a consequence								
eath certificate be attending physicia for use as the bur	ledica		d									
the death cer y the attendin	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Petal death at time of death		ctopic pregnancy ther (specify)	/			23d.	Date of del Month	ivery Day Year
wrequires that the de been signed by the should be detached	by	Part II. Other significant condition	ons contributing to death	but not resulting in	n the unde	erlying cause giv	en in Part I	l.		tobacco use o		the cause of death?
vical necessity (sector, page 2 sh	Completed								24a. Was auto perfo 1 Yes	psy ormed?	prior to death?	itopsy findings available completion of cause of 2 No
hysicial hysicial nis certii	To Be	25. Was case referred to medica examiner? 1 □XYes 2 □ No	Hospital:	tient 2 🔀 ER/Ou	utpatient	3□ DOA Oth	OF.		h <i>(Check only i</i> me 5 ☐ Resi		Other (Spec	cify)
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physicis in by the funeral director, page 2 should be detached for use as the but	Certification:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Hennicide	gation 8/004		Time of Injury		y at k? Yes 2	No	28d. Describe Selp. 28f. Location (A Ph	7	iral Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	edical Cer	29a. Certifier 1 ☐ Certifyin	ng Physician: To the bes Examiner: On the basis and manner s	st of my knowledge of examination an	31 Au	ccurred at the tir	ne, date ar pinion, dea	nd place, ath occurr	and due to the	rause(s) and	manner as	te land
To th within To th compl	Me	29b. Signature and title of certifie	· · · · ·			29c. Licens				29d. Date sig		,
3		30. Name and address of person	, .	death (Item 23a)		nt)					-	
		31. Date filed (Month, Day, Year)		trar's ignature		TIT Leur	Str	eet,	Baltim	ore, M	aryla	nd 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:35 AM /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner KIVERVIEW CSS & If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year 3ex 1□M 2**X**F Funeral Months Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "netural", or Items 23a or 28a-f eho other traumatic event, the Medical Examiner must be notified at MD ESSEX 10f. Zip Code 1 ☐ Yes 2 No by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 21221 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) at home noneman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) mielinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222. 20b. Place of Disposition (Name of Importent: If item 27 any injury or other tr 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Ligenses Timonium MD 21093 PEACEFUL ALTERNATIVES FUNGRAL CREMATION CTR 23a. Part1. Enter the disea shock, or heart failure tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause of each life. Physician Immediate Cause (Final disease or condition resulting in death) 4-5 days /Medical Examiner Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 by Physician/Medical Due to (or as a consequence of): d for use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy TOYES 20 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Dedrising Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 ☐ No After this 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. Director: Aft 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: A completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier (Check only one) 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08-11-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASTBEN BLUD - MD-21221

State Registrar

AUG 1 3 2004

31. Date filed (Month, Day, Year)

WASBEM.

709.

32. Registrar's Signature

or Print in Black Indelible Ink

			For State Registrar	State of		/ Depa	artment of h tificate of	lealth and	-	ygiene	ol one						
	ာ Physici	an	1. Decedent's Name (First, Midd James E. Kelle			Cer	uncate or	Dealli	2. Date of D	Reg. No. Death 1 7 Day 200	3. Time of Death 4 Year 11:15 a						
	/Medic Examir		4a. Facility Name (If not institution 202 Idlewild	on, give street and nun			4b. City, Town, o	r Location of Deat	h	4c. Count Harf	y of Death ord						
	Funeral Director		5. Social Security Number 213–34–6998		7. Age (In yrs. las 66	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, I	Birth (Day, Year) 12, 1937	Birthplace (State or Fore Country) New York						
	p		Usual Residence of Decedent 10a. State 10b. Count Md. Har	y ford	10c. City,	Town or Lo	cation Bel A	ir			10d. Inside City Limi						
	ith the Ma or 28e-1 s	Directo	10e. Street and Number		20		10f. Zip Code	21014			What Country? States						
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or items 23a or 28e-1 show event, I're Medical Exactive must be routhed at	by Funeral Director	202 Idlewild 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	12. Was Dece Armed Fo 1 Yes	dent Ever in U.S. rces? 2 \(\) No	1	Was Decedent of H f Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer	Specify Yes or Note Rican, etc.)	No- 14. Ra Bla	ce - American Indian, ack, White, etc.						
Maryland 21215-0036	d within 72 hou plene. r than "nature I've Medical E	Completed	15. Decede (Specify only high Elementary/Secondary (0-12) 12 years	est grade completed) College (1	-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking		Business/Industry Security Admi:						
land 2	ould be filed Mental Hygie arked other atic event, II	To Be C	17. Father's Name (First, Middle James P. Kell						me (First, Midd rances	le, Maiden Suma Hill	тө)						
Mary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	-	19a. Informant's Name/Relation Rosalie A. Ke			19b. Mailir 202	ng Address <i>(Street</i> Idlewild	and Number or R. Road, A	urai Routa Num pt. 2C,	Bel Ali	State Zip Code 1014						
Baltimore,	Pages 1 ar lent of Hea nt: If item 2 ry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 1 ☐ Donation 5 ☐ Other (State Bayy	ce of Dispo netery, cren view (sition (Name of natory or other pla Crematory	8/11	Date / 2004		- City or Town, State ore, Md.						
Balti	permit. Pages Department of the Importent: If ite any injury or of once.		21. Signature of Funeral Service	e Licensee	10	22					Air, Inc. Md. 21014						
	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	st only one cause on e	aused the death. ach line. or as ponseque	Can	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,	Approximate Interval Between Onset and Death						
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3760,	certificate be executed ording physician and use as the burial-transi	cal	rosaling in assum East	d.	or as a conseque												
O. Box 68	death e atter id for u	ysiclan/Med	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregnanti inth 2 Fetal of ant at time of dea own	leath 3 □	Ectopic pregnanc	у			ate of delivery onth Day Year					
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S	The law ate has b page 2 sl	Completed							24a. Wa aut per 1 \(\text{Yes}	formed?	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No						
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of	ing Phys After this uneral di	tlon; To	1 Yes 2 No 27. Manner of Death 1 Hatural 5 Pend	28a. Date	npatient 2 E of Injury th, Day Year)	R/Outpatien 28b. Time of Injury	28c. Inju Wo	4 🔲 Nursing i		sidence 6 Ot how injury occu							
Division	al or Attending safter death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could	d not be 28e, Place	of Injury - At hom ng, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or T	(Street and Num own, State)	ber or Rural Route Number,						
	the Hospitel thin 24 hours a the Funeral to mpletely filled	edical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ring Physician: To the al Examiner: On the b and man	best of my know asis of examinationer stated.	ledge, death on and/or in	n occurred at the ti vestigation, in my o	me, date and place opinion, death occi	e, and due to th urred at the time	e cause(s) and me, date and place,	anner as stated. , and due to the cause(s)						
25	To the within 2 To the complet	Me	29b. Signature and title of certif	ier /)/)			29c. Licens	se number	as Í	29d. Date sign	ed (Month, Day, Year)						

29d. Date signed (Month, Day, Year) 8/09/04

npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con

29c. License number
D0053694

Che saperko Dr Suik 31 520 31. Date filed (Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Joseph Kolar, Jr. Stephen 9 2004 2:15 A August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Campus Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 20, 1937 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 □ F 67 Yrs. Maryland 215-34-7871 **Director** Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Directo Bel Air Maryland Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 805 E. Broadway 21014 U.S.A. nit. Pages 1 and 2 should be filed within 72 hours after death variment of Health and Mental Hygiene. ortent: If item 27 is marked other than "naturel", or Items 23 injury or other teumatic event, Its Mendest Examination Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ծ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Friends School Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ellen Stephen Joseph Kolar, Sr. Hart 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Margaret Kolar (wife) 805 E. Broadway, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Gardens of Faith Cem. 8/12/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of ming, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) roy Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Yes 25. Was case referred to examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Medical Certification: To 1 Tyes 2 00 2 ER/Outpatient 3 DOA Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Ccident Injun 5 Pending 1 Yes 2 No death. investigation after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide Hospital within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated. 29a. Certifier Avestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the h 29b. Signature and the of certifier 29d. Date Signed (Month, Day, Year) 32 Bec State

Registrar

State of Maryland / Department of Health and Mental Hygiene For Stete Registra Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month 11:20 AM **Physician** 10 2004 AUGUST KREYMANN WERNER /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Months Hours 1 X M 2 □ F Yrs. September 27, 1921 Germany 218-42-8464 82 Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10h County 10c. City, Town or Location 10a State in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Ves 2 No Mary land N/A Baltimore the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with t 21214 USA 5510 Plymouth Road death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I □ Yes 2 □ No If Yes, Give XX Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Baltimore, Maryland 21215-0036 Š 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed College (1-4or 5+) Elementary/Secondary (0-12) Electrician German Merchant Marines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I 1 and 2 should be Adolf Kreymann Emmy Inknown ൧ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is a any injury or other treut 00028. 5510 Plymouth Road Baltimore Maryland 21214 Evelyn Kreymann / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 \$\mathbb{M}\$ Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemeterv 8/14/04 Baltimore Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore Maryland 21214 mosteria 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2DAYS Pnysician SEPSIS /Medical Due to (or as a consequence of): **Examiner** SDAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Ď 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records. 1 Yes 2 No 3 Probably 4 Onknown ed bluods END STAGE RENAL DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death? ASCITES page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 20 No certificate Division of Vital or Attending Physician: 26. Place of Death (Check onl. one 25. Was case referred to medical examiner? director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: patient 2 ER/Outpatient 3□ DOA 1 Yes 2 this 28c. Injury at Work? 28d. Describe how injury occurred tuneral 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Atter Injury 5 Pending investigation **L** Natural 1 ☐ Yes 2 ☐ No hours after death. unerel Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide in by determined 4 - Homicide within 24 hours a To the Funerel C tilled Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier RES 000 6 BOKEY 8110104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL GILBERT BOURTEILY, 5601 LOCH RAVEN BLVD, BALTIMORE, MD 21239 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #5 PER PH C835 9 POST HELE ATT OF Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 08 2014 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimore Miryland 6. Sex Modical CTR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country) April 30,1928 New York 092ª20º0497º 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 283F 092-20-0487 Director 76 April Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 20No Director Maryland Baltimore White Marsh 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5809 Gambrill Road 21162 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or iten eny injury or other traumatic event. It a Mudical Examinations. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assistant School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Ellison Marie Stole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Gambrill Road, White Marsh, Maryland 21162 Charles Kress (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gard. Aug. 12, 2004 Baltimore, Maryland 21 Signatur of Fineral Species bicensee ²² Name and Address of Facility
Bruzdzinski Funeral Home, p.A.
1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: BSI 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of deeth 5 Other (specify) o 9 Unknown 9 Unknown ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform page 2 🗆 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending PASSANCER IN MOTOR VEHICLE COLUSION July 23.2004 1616 PM within 24 hours after death. To the Funeral Director: A investigation 2 Seccident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) RAPHEL R-O AND IMT, VISTARD. in by 4 - Homicide ROADWAY MARSH MO Fo the Hospital 29a. Certifier Mertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b Signature and title of a rtifier AU 4176435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) AUG 1 3 2004 Registrar's Signature

Greene St. R. Himor My

Physicia	an	1. Decedent's Name (First, Middle, Last) Darryl L. Lynch			2. Date of Death Month	Day Year 0622 7		
/Medic	al	4a. Facility Name (If not institution, give street and number,		4b. City, Town, or Location of Death	AUG. 5	2004 0622 A		
Examin	er	UNION MEMORIAL HOSPITAI		BALTIMORE CITY		N/A		
Funeral Director		5. Social Security Number 6. Sex 7. Ag 2 ☐ F	ge (In yrs. last birthday) 45 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Yo			
3		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Lin		
or 28a-f show	tor	Maryland N/A	Balti			1_ Yes 2		
or 28a-f	Irec	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?		
23a c	ralD	409 Charter Oak Avenu	e	21212		USA		
and Mental Hygiene is marked other than "natural", or Itams 23a or 28a-f show aumatic avant, the Modical Estanitistic out be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces* 1 Yes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black		
"natural", Jiral Ex.	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	king 16	b. Kind of Business/Industry		
han "	mpl	Elementary/Secondary (0-12) College (1-4or	5+)	kind of work done during most of work DO NOT use retired)	i.i.rg			
Hygie thert	CO	12th grade 17. Father's Name (First, Middle, Last)	Ne	ver Employed	ne (First, Middle, Mai	iden Sumame)		
ked o	To Be	Luke Lynch		Queen 1		den damane)		
Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic avant. If e Madical once.		19a. Informant's Name/Relationship (Type, Print) Gordon Lynch/ Brother		ng Address (Street and Number or Au Greenspring Av		Sity or Town, State, Zip Code) 212 ltimore, Marylan		
of Haalth fitam 27 rother tra		20a. Method of Disposition	20b. Place of Dispo	- CALANTONIA TAKE	The state of the s	c. Location - City or Town, State		
nent o		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	Mt. Zio	n Cemetery 8/	12/04 Ba	altimore,Maryla		
Departmen Important: any injury Once.		21. Signature Funeral Service of nsee	5.	2. Name and Address of FacilityCha 240 Reisterstov	atman-Ha: wn Rd Ba	rris Funeral Ho ltimore,Md21215		
		23a. Part1 Enter the disease, or complications that cause shock, or heard tailure. List only one cause on each I Immediate Cause (Final	d the death. Do not ent ine. e Disorder	er the mode of dying, such as cardiac	or respiratory arrest,	, Approximate Interval Betweer Onset and Deat		
ysician Medical		resulting in death)	a consequence of):					
aminer		Sequentially list conditions b.						
sit	Inei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Consider the United States of Lighty	a consequence of):					
ohysician and the burial-transit	ical Examiner	that initiated events c.	a consequence of):					
attending ph I for use as th	Physician/Medi		2 Fetal death 3]Ectopic pregnancy		23d. Date of delivery Month Day Year		
by the ached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	t time of death 5	Other (specify)		Widthit Day real		
een signed lould be det	Completed by	Part II. Other significant conditions contributing to death technolism	out not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death		
					24a. Was an autopsy performed			
certil	o Be	25. Was case referred to medical examiner? 1 XYes 2 □ No Hospital: 1 □ Inpati	ent 2X ER/Outpatien		th (Check only one)	a F304 (0 4)		
h. After th funeral	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ury 28b. Time of			ne 5 Residence 6 Other (Specify) 8d. Describe how injury occurred		
s after deat I Diractor: d in by the	Certification:	3 Suicide 6 Could not be	jury - At home, farm, str. c. (Specify)		28f. Location (Street City or Town, S	ition (Street and Number or Rural Route Number or Town, State)		
	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and/or inv	n occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
n 24 hours ha Funaral bletely fillec	Q1 .	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)		
within 24 hours To tha Funara completely fille	Me	1 1 11				0.1163		
4 L 0	Me	30. Name and address of person who completed cause of a	1	O.C.M.E		AUG. 2004		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 9 11:25P^M 2004 August Joseph Leroy Lilley /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Catonsville Baltimore Mariner Health Care of Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☑ M 2 🗆 F Yrs. Aug. 30,1920 Maryland 83 219-07-3525 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be recitive. 1 ☐ Yes 2X No Directo Maryland Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 U.S.A. 409 Waveland Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No tf Yes, Give Year or Dates: WW II 14. Race - American Indian, 11. Marital Status Black, White, etc. ited within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Supervisor C&P Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Iverna Kelley Joseph Oliver Lilley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 409 Waveland Road Catonsville, Maryland 21228 Catherine L. Lilley (Wife) Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Meadowridge
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 8-13-2004 Elkridge, Maryland 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee 1630 Edmondson Avenue Catonsville, Maryland 2122¢ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscierone cardiovascular Disease **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day ò 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Ö 9 Unknown 9 Duknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Obstructive Pulmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 No 1 🗌 Yes rs after death.
rel Director: After this cer... Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 5 Pending 1 Natural 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number > Karen & Balett, M.D. August 10, 2004 D2058676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 25 Main street, suite 200, Reisterstown, MD 21136

DHMH 17 Rev 1/200

State

Registrar

Karen L. Babitt

AUG 1 3 2004

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2<u>004</u> Month Year **Physician** August 7, Larson 6:20 pm^M Herbert Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Anne Arundel 253 B&A Blvd. 8. Date of Birth (Month, Day, Year)
Dec. 26, 1932 If Under 1 Year | If Under 24 Hrs. Wonths Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Vrs 334-26-1607 71 Director Minnesota Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Crownsville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21032 76 Summerhill USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural; or Items 23a empiniury or other freumatic event, I'm Medical Examinational Doce. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: þ 1951-55 White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Computer Specialist NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Larson Tillie Olson 19a. Informant's Name/Relationship (Type, Print) (Step-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son) Clarence A. Pannuty, Sr. 253 B&A Blvd., Severna Park, MD 21146 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Cem. 4 ☐ Donation 5 ☐ Other (Specify) 8-10-2004 Crownsville, MD 21. Signature of Funeral S 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Milawaa Metrosentic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ₩o 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 5 Residence 6 Other (Specify esidence Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 70 ieral Director: After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury Certification: Injury (Month, Day Year) 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 038409 related cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who co

AUG 1 3 2004

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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Hyir, Whaily, rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 8, Day 2004 Year **Physician** 1442 Carroll James Mullen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) Aug. 11, 1913 #341145 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Maryland 90 Yrs 216-01-5528 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Abingdon Harford 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code ō 21009 309C Tall Pines Court Itams 23a Completed by Funerai 12. Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō white 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. h and Mental Hygiene. 7 is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) trucking salesman Carrol 11 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Ernstberger ္ရ Francis Mullen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 309C Tall Pines Court, Abingdon, Md. 21009 Charlotte M. Mullen/wife item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition o = 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ŏ Department of Important: If any injury or 8/13/2004 5 ☐ Qther (Specify) Baltimore, Md. ° 4 ☐ Donanion Bayview Crematory 21. Signature of Fundral Jenice Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician METASTATIC PROSTATE YORS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DISEASE 1 Yes 2 No 3 Probably 4 Unknown ARTERY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ² 1 ☐ Yes 2 X No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide in 24 hours. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2004 16h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INORTH BEL AR

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) AUG 13 2004 32. Registrar's Signature

			1 - For State Registrar	State of Marylar		artment of H			ene	1. 25571				
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Shirley Mackay					2. Date of Death Month		3. Time of Death Year 1004 /2:/0 PM				
	Examir		4a. Fecility Name (If not institution, give s Mariner Health 5. Social Security Number 6. Sex	,	Air last birthday)	4b. City, Town, or Brewley	Air	1	4c. County o	of Death Ford				
	Director		393-30-2860 ¹□ Usual Residence of Decedent	M 2√F 69	Yrs.	Months Days	Hours Min.	(Month, Dav. Y	1935	9. Birthptace (State or Foreign Country) Illinois				
	ter deeth with the Marylan items 23a or 28a-f show the motified at	ctor	Md. 10b. County Harfor		ty, Town or Lo	Bel Ai	r			10d. Inside City Limits 1 ☐ Yes 2 ♣ No				
	h with the 13a or 28	al Director	10e. Street and Number 1403 Loch Carron V	lay		10f. Zip Code 2101	.5		. Citizen of Wi United					
036	72 hours after deeth with the Maryland natural', or items 23a or 28a-1 show dical Exambre invite invitted at	by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (S) In, Mexican, Puert Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes		- American Indian, White, etc. white				
Maryland 21215-0036	withIn ene. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor	king	b. Kind of Bus (Dupo					
land	ould be filed Mental Hygi arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Irving Lanning					Lyons						
Mary	d 2 should be th and Mental ?7 is marked traumatic ev	-	19a. Informant's Name/Relationship (Typ	•				ral Route Number, C Bel Air,						
Baltimore,	permit. Pages 1 end 2 should b Department of Health and Menta Importent: if item 27 is marked any injury or other traumatic e ance.		Cathie Stewart/day 20a. Method of Disposition 1 Burial 2X Cremation 3 Re 4 Donation 5 Other (Specify)	20b. I	Place of Dispo	sition (Name of matory or other place Crematory	e)	Date 20		ity or Town, State				
Balt	permit. Departr imports any inj		21. Signature of Funeral Service License	Rineke	\		k Funéral	Home of						
	Physician /Medical		23a. Part1. Enter the disease, or comption shock, or heart failure. List only one timmediate Cause (Final disease or condition resulting in death)	ations that caused the deale cause on each tine.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest		Approximate Interval Between Opset and Death				
8760,	cate be executed physician and the burial-transit	Physician/Medical Examiner	cal Examin	cal Examin	cal Examin	cal Examin	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
.O. Box 6	the death certifi y the attending ched for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 No 9 □ Unknown	c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	-				
ords, P	v requires thet been signed b should be deta	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobad	~ /	ute to the cause of death?				
Vital Records,	The law ete has b page 2 s	Completed	Of Wassesseller					24a. Was an autopsy performed 1 Tes 20	d? prid	re autopsy findings available or to completion of cause of ath? Yes 2 \sum No				
of	ding Phys	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	at Vursing Ho	h (Check only one) ome 5 Residence 28d. Describe how						
Division	후	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural to City or Town, State)							or Rural Route Number,				
	To the Hospital or At within 24 hours efter or To the Funeral Direction place of the funeral Direction by the funeral filled in by	edical (29a. Certifier (Check only one) 1 Certifying Physical Certifier (Check only one) 1 Certifying Physical Certifier (Check only one) 2 Certifier (Check one)	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	e, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and mann and place, and	er as stated. If due to the cause(s)				
2	To the within To the comp	Me	29b. Signature and title of certifier	ND		29c. License		29d. Ang	Date signed (Month, Day, Year)				
	07		30. Name a address of person who com	pleted cause of death (Item	n 23a) (Type,	Print) Inuc Bi	1 Air	Manyl	and	21014				
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 3 2004	32. Registrar's Signa	ature					,				

Amend item#5perFH, G834, 8/17/04 TI
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U U 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1515 PM AUG Maria Nella Mosca 04 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** BALTIMO.
If Under 1 Year If Under 24 Hrs. MORE HEALTHCARE SAINT AGNES Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 ★ F **Funeral** Months Days Hours Min. March 12, 1910 Director Italy Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County rel', or Items 23e or 28e-f ehow Examiner must be notified at 1 Yes 2 □ No Maryland N/A Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 246 Mallow Hill Road 21229 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1□Yes 2No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 □ Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) other then 3 Years Clothing Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be f nd Mental I Vittorio Cantalupi Angelina DiOdoardo le marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depintment of Health and Importent: If item 27 le m any injury or other treum once. 246 Mallow Hill Road Baltimore, Maryland 21229 Concetta Mosca / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition New Cathedral Cemetery 8/16/2004 Baltimore, Maryland 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licenses Nana 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** WEEK /Medical Due to (or as a consequence of): Examiner ATRIM Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transi FULTONAR Due to (or as a consequence of): 68760, Physician/Medical use as the Box IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, CANLER 1 Yes 2 No 3 Probably 4 Wonknown COLON Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 2 No 1 ☐ Yes Vital V Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 panpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospitel o within 24 hours af To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Hous E AUG 12 2004 00057216 1>HYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) BATHLO, M.D. MICHAEL SAH, 900 (ATON AJE, BALTIMORE OND 82. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 3 2004 Registrar

04-05197 VICTORIA L MINGEE WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unpend	it	Em Registrar # 23a, 27,	State of Mary 28a-f, per	ME G8349	8#123/0401	neailtí and Ta eath	-	Reg. No. 0	4 25574
Physic		1. Decedent's Name <i>(First, Middle, Las</i> Victoria Le	,				2. Date of De Month AUGUS	Day	3. Time of Death 14:38 P M
/Medi Exami		4a. Facility Name (If not institution, give 1416 NEW WINDSOR			1	or Location of De WINDSOR		4c. County o	
Funeral Director			9x 7. Age (III ☐ M 2☐ F 39	n yrs. last birthday) Yrs.	If Under 1 Yea Months Days			1965	9. Birthplace (State or Foreigr Country) Md
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County M d Carrol		Sykesvi					10d. Inside City Limits 1 ☐ Yes 2 🎇 No
with the (3a or 28s	I Direc	10e. Street and Number 6548 Sykesville	Road		10f. Zip Code 21784	ł		10g. Citizen of WI	nat Country?
ges 1 and 2 should be filed within 72 hours after deeth with the Maryland at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinator must be nutified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🂢 No	ban, Mexican, Pue	Specify Yes or No irto Rican, etc.)	Black	- American Indian, White, etc. White
filed within 72 hours aff Hygiene. other than "natural", or sort, If e Medical Exam	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12			dent's Usual Occi kind of work done DO NOT use retir Li assist			16b. Kind of Bus	,
d 2 should be filed within the and Mental Hygiene. It is marked other than traumatic event, Ite M.	To Be	17. Father's Name (First, Middle, Last) Henry Louis Ming				Ruth Ma	rie Lee	, Maiden Surname	
1 and 2 sho Health and tem 27 is m		19a. Informant's Name/Relationship (7 Ruth Marie Minge	e (mother)	6548	Sykesvil		Sykesvi1	er, City or Town, S le, Md 2	
E pi ti		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Lake View	matory or other pl v Memoria	1 8-1		20c. Location - C Sykesvill	le, Md
permit. Pa Departmen importent: any injury once.		21. Signature of Funeral Service Licen Puge Haight		22 F	2. Name and Addr	ess of Facility Ha 195 Syke	ight Fun	eral Home Md 21784	e & Chapel
Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or composition shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, isading to immediate	Citalopra a. Due to (or as a co	m and Que				rrest,	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of):					Ų
death certifi e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	sy		23d. Date Month	
The law requires that the ste base been signed by the page 2 should be detached	by	Part II. Other significant conditions co	entributing to death but no	ot resulting in the u	nderlying cause g	ven in Part I.			ute to the cause of death? Probably 4 Munknown
	Completed				·			psy prior pr	re autopsy findings available or to completion of cause of ath?
sician: certific irector,	To Be (25. Was case referred to medical examiner? 1 Yes 2 No		2 ER/Outpatien	IL SEL DOA	her: 4 🗍 Nursing	eath (Check only o		(Specify) SCENE
r Attending er death. irector: After i by the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide	28a. Date of lifeour (Month, Day 16 8/10/04 28e. Place of Injury - building etc. (S	4 .14	P M 1	Yes 2XNo	subject 28f. Location (5	Street and Number	ed medications or Rural Route Number, or Road
To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of miner: On the basis of exa	y knowledge, death	n occurred at the t	ime, date and place	e, and due to the	cause(s) and mann date and place, and	er as stated.
To the within To the comple	Me	29b. Signature and title of certifier	,	MA	29c. Licen	se number		29d. Date signed (i	Month, Day, Year) T 11, 2004
dr		30. Name and address of person who of Torsha Z Gryll (31. Date filed (Month, Day, Year)	ompleted cause of death			Penn St	reet, Bal	Ltimore,	Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MAR Manillan Aucus 2000 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 418SpiTAL CENTER RANDA (Stown NO RTHWES, BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 17 Birthplace (State or Foreign Country)
 Md 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 JyF Months 219-22-8358 78 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, the Medical Example right be notified at Baltimore Woodstock 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 2101 Ramona Lane 21163 USA items 23e 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ∏ No Specify: 3 Widowed 4 Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 bookkeeper clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental I Emma Dorsey Darwin H. McCracken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary McMillan (son) it of Health 2101 Ramona Ln., Woodstock, Md 21163 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial 8-14-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee

Parge Hougest S P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASYSTOLE resulting in death) /Medical Due to (or as a consequence of): Examiner 18 EHEMIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Be Completed by Physician/Medical Examiner use as the burial-transit law requires that the death certificate be executed PUST (ZFT Box 68760, WEMMA IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 Yes 2 No Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. I 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ HKnown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a. Was an autopsy performed? CHRIM.C Pactoria J□ Yes 2 NO Vital the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 21 No Certification: To 1 Hnpatient 2 ER/Outpatient 3□ DOA Division of his funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred 28b. Time of After Natural 5 Pending 2 🗌 No death. investigation 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 219502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nontowest HOSPITAL CENTER B. CONANAL My ORCANDO 34 Registrar's Signature 31. Date filed (Month, Pay. 3°2004 Registrar

JOZEF MAJKA 04-5134 WHN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Unpend item # 23,27, per ME, 6834,8/30/04 II

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Funeral			34-94-3114	6. Sex	7. A		last birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	B. Date of Bir (Month, Da	th i <i>y, Ye</i> a	9. Bi	rthplace (State or Ford country)
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item 27	1. 7		etty L. Mor	ris (Mother)	1001 5				lence Roa				
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Amend item #5, per FH, 6835, 9/8/04 11
State of Maryland / Department of Health and Mental Hygiene 1- State Registra MEND TTEM #20b PER FH C834 8/17/100 Death

1. Decedent's Name (First, Middle, Last) Reg. No. 3. Time of Death 2. Date of Death Month Dav Vear **Physician** 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) 6. Sex **Funeral** Days Months Hours 1 ☐ M 2 💢 F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "netural", or items 23a or 28e-f show other traumatic event. Its Medical Examiner must be retified at 1 Yes 2 □ No Maryland Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mon14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after theath and Mental Hygiene. Heath and Mental Hygiene. em 27 Is marked other than "netural", or Itel 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry omes 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mc (Son) Informant's N / e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St eman surnie Va 21060 GIE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō <u>=</u> 1 ☐ Burial 2 TCremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/18/04 IT ō Green Mount Crematory Department of Importent; If any injury or once. 21. Signature of Funeral Service Licensee 22 Name and Address of Fully Joseph L. Russ Fu Zzzz W. North Ave. Funeral Balto Md. 21216 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UL MONARY Physician ARDIO /Medical Due to (or as a consequence of): Examiner ASC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b Irector, page 2 s autopsy performed 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient ∠2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 124 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the within 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2 081004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MNAPOLIS 301 KOAD

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 **Physician** August 8, 2:20 a M James Elmer Mauler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F Yrs. 215-14-5843 Jan.23,1920 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits traumatic avant, the Medical Examiner must be notified at 1 Yes 3 No Maryland Baltimore Directo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 921 Southerly Road Apt. 2 21204 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Toy Store Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Elmer Mauler Virginia Seal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i Virginia B. Zimmermann/Niece 700 Providence Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ita any injury or otl once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/10/04 Druid Ridge Cem. * 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASDINATION week /Medical **Examiner**

this

After

hours after death unaral Director:

within 24 hours a

Examiner Physician/Medical 23b. Was decedent pregnant Be Completed by 25. Was case referred to medical examiner? Certification: To 27. Manner of Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

in the past 12 months? 1 ☐ Yes 2 ☐ No

Dementin

1 ☐ Yes 2 No

1 Natural 2 Accident

3 🗀 Suicide

29a. Certifier

4 Homicide

(Check only

9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

28a. Date of Injury (Month, Day Year)

Dua to (or as a consequence of)

Due to (or as a consequence of):

3 ☐Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VASCU (N disease

24a. Was an autopsy performed?
1 Yes 2 No

balto md 2 (204

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

AUGUST 8, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G-BMC 6701

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 1 3 2004

5 Pending

investigation

6 Could not be determined

32, Registrar's Signature

Division of Vital Hospital or Attending Physician:

N. Chan

2:57AM

ANASTASIA

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			Registrar I. Decedent's Name (First, Midd	le, Last)		-1-416				- Journ		2. Date of D	eath	and the same of th	3. Time of De	eath
Physi /Me			Anastasia				Magge	lakis	3			August	t 9,	2004 Year	2:57 A	М
Exan			la. Facility Name (If not institution	n, give street	and nun	nber)				Location of	of Death			c. County of Dea		
		5	Gilchrist 5. Social Security Number	6. Sex		7. Age (In vrs	s. last birthday)	If Under	JSO∏ 1 Year	If Under	24 Hrs.	8. Date of B	irth	o Ri	Thplace (State or F	oreiar
Funera Directo			212-10-3970 Jsual Residence of Decedent	1 □ M		87	Yrs.	Months	Days	Hours	Min.	(Month, D March	25 1	,1917	Maryland	
faryland show		1	10a. State 10b. County	imore			City, Town or Lo Baltimo								10d. Inside City I	
the h		1	10e. Street and Number					10f. Zip	Code				10g. (Citizen of What C	ountry?	
th with	1	2	8710 Fowler A	ve.				212	234					United	States	
ine, with yield X 12.15.0000 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menlar Hyglene. filed 71 a marked other than "natural; or Itams 23e or 28e-f show other traumatic event, the Medical Examinat must be notified at		Dy runer	11. Marital Status 1 □ Never Married 2 □ Ma. 3 ☑ Widowed 4 □ Divorce	rried 1	vas Dece imed Foi □Yes Yes, Giv Year or Da	2 💢 No e		Was Deced f Yes, spec 1 ☐ Yes		ispanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify:		
2 hours			15. Decede	nt's Education	1	1100.	16a. Dece	dent's Usua	al Occup	ation		·	16b.	Kind of Business	s/Industry	
within 7. Jene.		nalaldillon	(Specify only higher Elementary/Secondary (0-12)		ripiete <i>a)</i> Sollege (1	-4or 5+)	life.	ntrer	se retired		t of work!	ng	5	elf Empi	Loyed	
al Hyg		ם ב	17. Father's Name (First, Middle	, Last)			'	'				(First, Middle				
should be nd Mental I marked c	F	2	James Lambro								sili		rtes			
and 2 sh and 2 sh salth and n 27 la m	1		19a. Informant's Name/Relationship (Type, Print) Sophia Vendelis/daughter 19b. Mailing Address (Street and Number or Rural Route Number or Paral Route Number or Rural Route N									ım,	Maryland	21 204		
permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other		2	1 Rurial 2 Committee 3 Removal from State cemetery, crematory or other place)											Location - City o		٠.d
nit. Pa artmer ortant: injury	ri I	'n	Commetery, crematory or other place)												, Marylan	
permit. Departr Imports any inji	once		Stephen	T. Cal	ter						Nu			runeral and 2120		ic.
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/Medica Examina	-			6 b	Due to (or as a conse	equence of):	str		- 22					mon	the
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rtificat ng phy	3		IF FEMALE:													
The Coulds, F.C. BOX 801000. The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 4	Live b	come of preg irth 2 Fe ant at time of own	tal death 3	Ectopic pr Other (sp						23d. Date of de Month	livery Day Yea	ır
s that t ned by e detac	d	E -	Part II. Other significant condit				esulting in the u	nderlying c	ause giv	en in Part I.		23e. Did	tobacc	use contribute t	o the cause of deat	th?
w requires been signa should be		najai	Seizure	0150	Y d 4	R	-					1 🗆	Yes	2 No 3 □ P	robably 4 Unk	nown
VICAL DECK Sician: The law r certificate has be lirector, page 2 sh		Comple		<u>.</u>								24a. Wa: auto perf 1 \(\text{Yes}	opsy formed?	prior to death?	utopsy findings ava completion of caus	
vital ician: Sertifica ector, p			25. Was case referred to medic examiner?								of Death	(Check only				
al alia	ı	0	1 ☐ Yes 2 🗶 No 27. Manner of Death 1 🗷 Natural 5 ☐ Pend		a. Date		ER/Outpatier 28b. Time of Injury		8c. Injun Wor	v at	2	me 5 Res 28d. Describe			ocity) Hospi	Ce
INITIAL INTERPRETATION To Attanding after death. Diractor: After in by the fune		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								(Street own, Sta	and Number or R ite)	ural Route Number	;		
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To the within To the comple		ພ ⊢	29b. Signature and title of certifi	er	1	-0				e number			. 1	ate signed (Mon		
			M. Hote	horry	Ke	Key,	an			250			14.	gust	9,2004	
6			30. Name and address of person		nted caus	e of death (It	em 23a) (Type,	Print) har	les J	G. E	Bal	to m	ď	21201	<	
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			For State Registrar	State of Ma	arylan		artmen rtificate					Reg. No	nn	; Z	5581	
	Physici	an	Decedent's Name (First, Middle, L								Date of Dea Month	Da	•	'ear	3. Time of Death	
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	Funeral Director		212-30-2085	Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. 1	la <i>st birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da Sept.	th y, Year) 14,1	.932 F	enns	ace (State or Foreign ry) Sylvania	7
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside City Limits	_
	Maryi -f sho	호	Maryland Harf	ord		Bel Ai	r								M Yes 2 ☐ No	,
	r 28e	lrec	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wha	at Count	ry?	-
	23a c	aiD	213B Crocker Dr	ive				210	14				USA			
920	72 hours after death with the Maryland "naturel", or Items 23a or 28e-1 show official Examinatine must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spec I, Puerto R	cify Yes or No- tican, etc.)	-	14. Race · Black, Specify:	America White, e Whi	itc.	
21215-0036	72 ina	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5	5+)	16a. Deced (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired,	ition Juring mosi)	of workin	g	16b. K	ind of Busir	ness/Ind	ustry	
21		Con	12			[Lega]	Sec:	retai					egal			_
Maryland	ed fa	To Be	17. Father's Name (First, Middle, La. James Clay Adams	•							(First, Middle, e Locke		Surname)			
	-		19a. Informant's Name/Relationship ROSS T. MONKS/HU				-				Route Numbe Bel Air				Code)	
Jre,	ss 1 ar		20a. Method of Disposition		20b. P	lace of Dispo emetery, crer	sition (Nan	ne of ther place	9)	Da	ite	20c. Lo	ocation - Cit	ty or Tov	vn, State	
imo	Ross T. Monks/Husband 213 B Crocker Drive, 20a. Method of Disposition 125 Burlal 2 Cremation 3 Removal from State 4 population 5 Other (Specify) Churchville Pres. Cem 8-13									8-13-	-04	Chu	rchvi.	lle,	MD	
Baltimore,	permit. Page Department of Importent: If any injury or			and to	F	1	$50 W_{-}$	as Fi Bro	ınera adway	l Hon	ne, P.A	1 7	ir, M	21	014	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each li	t the death ne.	n. Do not ent	er the mod	e of dying	3, such as	cardiac or	respiratory ar	rest,		-	Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)			RICULA	AR DY	/SFU	NCTI	ON				1	HOUR	
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	nd nd transit	Examin	that initiated events	c												
30,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):										
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.O. Box 6	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	Ideath 3□	Ectopic pro Other (sp.						23d. Date o Month		y Day Year	
0	es tha igned be de	by	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying ca	ause give	in in Part I.		23e. Did to				e cause of death?	
I Records,		Completed						_			24a. Was autop	sy	prio dea	r to com th?	sy findings available pletion of cause of	
Vital	Physicien: 1 this certificat ral director, p	Be (25. Was case referred to medical examiner?					0.1		of Death	(Check only o	ne)				
of \	Phys this al din	6	1 ☐ Yes 2 🛣 No 27. Manner of Death	Hospital:		ER/Outpatien		ALC: UNKNOWN	4 LINU		e 5 🗆 Resid 3d. Describe h			(Specify)		_
		tion	1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year)	Injury	M	8c. Injury Work 1 ☐ Y	? ′es 2 🔲 !		od. Describe in	iow injui	y occurred			
Division	Hospitel or Attending 44 hours after death. Funerel Director: Afte tely filled in by the fune	Certification;	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	be Diese of lei	ury · At ho c. (Specify	ome, farm, str	eet, factory	, office		28	Bf. Location (S City or Tow			or Rural	Route Number,	
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in b	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best aminer: On the basis o and manner st	f examina	wledge, death tion and/or in	occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, ar	nd due to the d d at the time, d	ause(s) date and	and manne place, and	er as sta I due to t	ted. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and tute of certifier	AUX			290	. License	number		1	01	e signed (A	Month, D	ay, Year)	
,			11/7	rul			I	38	570			81	10/	04		
	12		30. Name and addless of person wh	o completed cause of c	eath (Item	1 23a) (Type,										
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	7601 ar's Signa			RIVE	_TÜW	SON	MARYL	AND	212	24		
	Regist	rar	AUG 1 3 2004	tous	St.	Good				.,-						

			For State Registrar			and / Depa		f Health a		ntal Hygi	ene g. N2. [] [] []	25582)
			Decedent's Name (First, Middle	, Last)					2	. Date of Death		3. Time of Death	i
	Physici /Medic Examin	al	Edna Leazer 3		umber)		4b. City, Tow	n, or Location of		Month August			М
	_ Admin		Gilchrist Hosp	ice			Tows	on			Bal	timore	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	rs. last birthday)	If Under 1 Ye Months Da		Min.	. Date of Birth (Month, Day,	Yeer) 9	Birthplace (State or Fore Country)	ign
	Director		249-16-8723 Usual Residence of Decedent	1□M 2∏F	81	Yrs.			8	3/17/192	22 S	outh Carolin	ıa
	r 28a-f show	_	MD Balt	imore		City, Town or Lo 'ullerto						10d. Inside City Limi	
	he M	Funeral Director		Imore	F	urrerro	10f. Zip Coo	10		10	Citizen of 14th		
	with t	ä	10e. Street and Number	2110				236		10	g. Citizen of What U.S.		
	leath	era	133 Sipple Ave	12. Was Dec	edent Ever in	U.S. 13.		of Hispanic Origi Cuban, Mexican,	in? (Speci	fy Yes or No-		American Indian,	
336	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by Fun	1 Never Married 2 Marri	Armed F ied 1 ☐ Yes If Yes, G Year or	2 No		fYes, specify (1□Yes 2,50x		Puerto Ri	ćan, etc.)	Black, Specify:	White, etc. White	
Maryland 21215-0036	uln 72 hours afi n "naturel", or Vedical Exami	Completed	15. Decedent (Specify only highes	t grade completed		16a. Dece (Give life.	dent's Usual Od kind of work do DO NOT use re	ccupation one during most o tired)	of working	1	6b. Kind of Busin	ness/Industry	
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. pu	e file al Hyg I othe vent,	Be C	17. Father's Name (First, Middle,	Last)					's Name (i	First, Middle, M	aiden Sumame)	0	
<u>a</u>	Menta	70 6	James Arthur L	eazar				Mar	y Jam	nes Coll	lins		
an	2 sho and ls mu		19a. Informant's Name/Relationsh	hip (Type, Print)			-				City or Town, Sta	·	
	and ealth m 27		Carl Mannel		l and					-	Marylan		
ore -	ges 1 t of H if ite		20a. Method of Disposition 1 XBurial 2 Cremation	3 Removal from	State	-	natory or other	place)	Dat		Oc. Location - Cit		
Ë.	Pactiment tent:		`4 □Donation 5 □Other (S)		G	ardens			8/13/			e, Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then any njury or other treumatic event, I'm Magnes.		21. Signature of Funeral Service I			6	415 Bel	air koa	d bal	timore,	Maryla	ral home Inc nd 21206	•
.1	Physician		23a Par 1. Ent of the disease, or shock, or hear failure. List Imm diete Cause (Final disease or condition	complications that only one cause on	caused the deepach line.	eath. Do not ent	er the mode of	dying, such as c	ardiac or r	espiratory arre	st,	Approximate Interval Between Onset and Death	0
d	/Medical Examiner		resulting in death)	Due to	(or as a cons	equence of):				1		1	
CV	nted insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bDue to	or as a cons	equence or):							
760,	ite be executed iysician and ne burial-transit	cai Exa	that initiated events resulting in death) Last	d.	(or as a cons	equence of):							
89	ng ph	Medi	IF FEMALE:										
P.O. Box	The law requires that the death certificativite has been signed by the attending phybage 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 TNo 9 ☐ Unknown	1 ☐ Live	atcome of preg birth 2 Fe mant at time of nown	etal death 3	Ectopic pregna Other (specify				23d. Date o Month	of delivery Day Year	
Ś	ulres that the signed by the detaction		Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	nderlying cause	given in Part I.		23e. Did toba	£	ite to the cause of death? Probably 4 □Unknow	vn
Record	The law requir ate has been s page 2 should	Completed								24a. Was an autopsy perform	ed? prio		le f
Vital		Ö	25. Was case referred to medical					26 Place o	of Death //	1 ☐ Yes 2) Check only one		Yes 2□No	
of Vi	this at di	ToB	examiner? 1 Tes 2 No 27. Manner of Death	Hospital: 1 _		ER/Outpatier	I SLI DOA	Other	sing Home	5 Residen	ce 6 Other (Specify) Hospica	
- u	Jing After	tion	1 Natural 5 Pending	g (Mo.	nth, Day Year)			Work? 1 □ Yes 2 □ N			many occarroo		
Division	or Attend after death Director: /	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 288. Plac	e of Injury - At ding, etc. (Spe	t home, farm, str cify)	eet, factory, off	ice	281	Location (Stre City or Town,	et and Number o State)	or Rural Route Number,	
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledicai C	29a. Certifier 1 Certifyin (Check only one) 1 Medicel	g Physicien: To th Examiner: On the and ma	e best of my k basis of exami nner stated.	nowledge, deat ination and/or in	n occurred at the vestigation, in n	e time, date and ny opinion, death	place, and occurred	d due to the cau at the time, dat	ise(s) and manne e and place, and	er as stated. I due to the cause(s)	
<u>.</u>	Fo the within Fo the	Me	29b. Signature and title of certifier		-0		29c. Lic	ense number		29	d. Date signed (A	Month, Day, Year)	
	->-0		VON HAD	rous Il	ily.	ans	Di	25 da	5		tuge	ST10,200	×
	10		30. Name and address of person	who completed cau	ise of death (III	tem 23a) (Type,	Print) //-	Cha	las	St. F	salts.	ST 10, 200	26
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Sig	gnature	1						
	Registr	rar	NUC 1 9 20	101 /20	neva	B	Monk	1					

DHMH 17 Rev 1/2001

a 4:45 AM

EDNA MANNEL - AUGUST 10, 20048 Division of Vital Records, P.O. Box 68760,

ORIGINAL

			1- For Amend Item 26	State of Mary per Verb.,	land / Dep 3834, Ce	artment of 3/04df	of Health a hb of Death	and Men	tal Hygie	ene i. No. 2 () ()	4 25	583
	Physici	an	Decedent's Name (First, Middle, Last) LANDENGE	MAC	CHOVEC,	r D			ate of Death	3, 2004 Ye	3. Time o	
	/Medic Examin	al	LAWRENCE 4a. Facility Name (If not institution, give st 8159 SUNSET DRIVE		DROVEC,	4b. City, Tov	vn, or Location	of Death	JGUST 3	4c. County of D) P M
	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) 32 Yrs.	If Under 1 Y Months Da	ear If Under ays Hours	24 Hrs. 8. C Min. SE	Pate of Birth Month, Day, Y	(ear) 1921	Birthplace (State Country)	
	Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD . N/A	100	BALTII			<u>.</u>			10d. Inside C	City Limits
	with the	Director	10e. Street and Number			10f. Zip Co		224	10g	. Citizen of What	Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any follow other traumatic event, the Medical Examinational De natified at DDCs.	y Funeral	1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Xes, Give		Was Decedent If Yes, specify 1 ☐ Yes 2 【】	of Hispanic Or Cuban, Mexica	n, Puerto Ricar	Yes or No- n, etc.)		merican Indian, hite, etc.	
21215-0036	thin 72 hours e. en "natural" Medical Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ. (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use re	one during mos etired)	-	I	b. Kind of Busine BALTIMOR	ss/Industry E CITY	
land 21	ld be filed wi ental Hygien ked other th ic event, the	To Be Con	12 17. Father's Name (First, Middle, Last) JAMES MACHOVEC			POLICE			st, Middle, Ma	MARINE D	IVISION	
, Maryland	and 2 shousalth and M n 27 is mar er traumat	_	19a. Informant's Name/Relationship (Typ) VIRGINIA MACHOVEC/W				reet and Numb	er or Rural Ro	ute Number, C	City or Town, Stat MARYLAN		
nore	ages 1 ant of He it: If Iten y or oth	٠.	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☑ Donation 5 ☐ Other (Specify)	moval from State	Ob. Place of Dispo cemetery, cre HOLY RED	matory`or other	r place)	Date AUG 7		BALTIMO		T.AND
Baltimore,	permit. F Departme Importen any injur		21. Signature of Funeral Service Licenses		2:	2. Name and A	ddress of Facili	ty CHAR	LES S.	ZEILER (& SON, I	NC.
	Physician /Medical Examiner		23a. Part T. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause on each line.	vascular		1 1	cardiac or res	piratory arrest		Approxima Interval Be Onset and Yww.k	tween Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Ilcal Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a con								
P.O. Box 6	death certif e attending ed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregn □ Other (specif				23d. Date of Month		Year
	sign d be	þ	Part II. Other significant conditions cont	tributing to death but no	t resulting in the u	inderlying caus	e given in Part I			cco use contribute		death?
Vital Records,	The ate h page	Completed							24a. Was an autopsy performe	d? prior death		available cause of
	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	ospital:	2 ER/Outpatie	nt 3 DOA	Othon	of Death Ch ursing Home -	/	ce 6 Other /9	pecifySon ts	
Division of	Attending Phys r death. ector: After this by the funeral dir	ation: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Yea	f 28c.	Injury at Work?	28d.		injury occurred	Resid	ence	
Divis	in Site	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)				City or Town, S			nber,
	To the Hospital within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Exemin	er: On the basis of exa- and manner stated.	/knowledge, deat mination and/or in	h occurred at the occurred at	he time, date ar my opinion, dea	nd place, and o ath occurred at	the time, date	se(s) and manner a and place, and o	as stated. lue to the cause(5)
		W	29b. Signature and title of certifier	Intra	mo	29c. Li	cense number	6	29d	Date signed (Mo	onth, Day, Year)	204
	0		30. Name and address of person who con Michele F. Bellan	mpleted cause of death	(Item 23a) (Type,	Print) Hanking	Bancis	Circle	Balk	08 -	20212	24
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 3 2004	32. Registrar's S		loo. V	,				7	-

			1- State of Maryland / Department of Health and N Certificate of Death		2001	orrol.
			1 - Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	2. Date of Death	g. No. U U 4	20004
	Physici		Louis G. Noetzel, Jr.	Month	Day Year	3. Time of Death
1	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	August	11, 2004 4c. County of Deal	9:50 A [™]
	Exami	ier	Greater Baltimore Medical Center Towson		Baltime	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
	Director		215-12-3673 AM 20 F 83 Yrs. Months Days Hours Min.	Dec. 29	1920 Ba	Fimore, MD
	pu *		Usual Residence of Decedent 10a. State /10b. County 10c. City, Town or Location			
	e Maryla 8a-f shov Aiffied at	ctor	Maryland Baltimore Co. Lutherville			10d. Inside City Limits 1 ☐ Yes 200 No
	hours after death with the Maryland tural', or Items 23a or 28a-f show Exarting frougher coulded at	ai Director	100. Street and Number 100. Street Spring Drive 21093	10	g. Citizen of What Co	ountry?
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo	ecify Yes or No-	14. Race - Ame Black, White	rican Indian,
36	s afte	by Fu	1 Never Married 2X Married 1 Yes 20 No Specify:	riioan, oto.)	Specify: (A)	hito
215-0036		g pe	SEL Wildowed 4 El Divorced Year or Dates:			111
5	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College f1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ing 1	6b. Kind of Business/	Α.
212	d within 7, giene. Ir than "n. Ir e Modi	omp	Elementary/Secondary (0-12) College (1-4 or 5+) Steam Ship Agen	it	Shipp.	ing
	be filed ital Hyg id othal	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	aiden Symame)	<u> </u>
laryland	d 2 should be th and Menta 7 is markad traumatic ev	ToB	Louis G. Noerzel, Sr. Marc	ella	Korn	
Σ,	s 1 and 2 s f Health and tam 27 is r other traur		Mrs. Els, e F. Noetzel (wife 19b. Mailing Address (Street and Number or Rural 1608 Greenspring &	Route Number,	City or Town, State, 2	MD, 21093
Baltimore	8 = 5		cemetery crematory or other place)	Date 21 14, 2004	Baltimor	
Balti	permit. Pa Departmen Important: any injury once.					emation CH D. 21093
			23a. Party. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	· Timo	nium, m	0. 210 93 Approximate
	Diameteria.		23a. PAny. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one choice or each line. Immediate Cause (Final	n respiratory arres	',	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Authority diffuse a.			Days
	Examiner		Due to (or as a consequence of):	0		1 0
4		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Xure		weeks
Λ	acuted nd transit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events			Mant
6	execan an an rial-tr		resulting in death) Last Due to (or as a consequence of):			T. Cong
876	ate be executed hysician and the burial-transit	dicai	d			
9		Ned	IF FEMALE:			
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	very
о. П	e dea he at hed fo	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
<u>Ч</u>	that the de led by the a detached t	Phy	9 U UNKNOWN			
Records,	op pe	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to 2 ☐ No 3 ☐ Pro	the cause of death? bably 4 Unknown
ပ္တ	aw requ s been 2 shoul	Completed		24a. Was an	24b. Were aut	opsy findings available
æ	The lay te has	mo		autopsy	prior to co	ompletion of cause of
Vital	an: tifica tor, p	a	25. Was case referred to medical 26. Place of Death		No 1 ☐ Yes	2□ No
	Physician: r this certific ral director,	To B	Hospital:		ce 6 ☐ Other (Speci	i6.1
0	ding Physician: The I h. After this certificate ha funeral director, page		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 2	28d. Describe how		197
Ö	uttendin death. ctor: Af y the fur	atic	2 Accident investigation M 1 Yes 2 No			
Division of	i or Attendation after deati	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Run	al Route Number,
	tal o rs aft al Di	Cer	Delianing, State (Specify)	City of Town,	natej	
	To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune.	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caused at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	To the comp	Me	29b. Signature and title of conflict	29d	. Date signed (Month)	Day, Year)
			MD D23166		8/11/	04
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 CYOSS To	ade 7	Drive S	uit- 10
	10		George 1. 1. 101 July DES M.D.	D.M	21117	0_/0
	Sta	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registra	ar	AUG 1 3 2004 Parent & Shorter "			

Physician John L. RIXON September	nd Mental Hygiene	partment of Heale		State of		For State Registrar							
46. City, Form, or Location of Death Name of me institution, give areas and mumber) 10. CITY OF THE CONTROL HOSE PITTAL				Last)			an	Physici					
Social Source Number 217 38 1010 Super Personnel Control Cont	Death 4c. County of Death		per)	-	(If not institution, g	4a. Fecility Name (al	/Medic	,				
The State of What Country and State of What					L010	217 38 1							
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LINDA JONES (SISTER) 2826 PELHAM AVE. BAITIMORE, MARYLAND 21213 20c. Location - City or Town - Camadiany, crimmatory or other place) Date 20c. Location - City or Town - Camadiany, crimmatory or other place) Date 20c. Location - City or Town - Camadiany, crimmatory or other place) Date 20c. Location - City or Town - Camadiany, crimmatory or other place) Date 20c. Location - City or Town - Camadiany, crimmatory or other place) Date 20c. Location - City or Town - Camadiany, crimmatory or other place) Date Camadiany, crimmatory or other place) Date	r's Name (First, Middle, Maiden Surname)	18. 1		ast)		17. Father's Name	Be	d other event, I	N D				
Table and a continue	LITIMORE, MARYLAND 21213	PELHAM AVE.	2826		ONES (SIS	LINDA JO		h and 7 is m traum	5 p42				
23a. Part I. Frier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. And the control of the cont	UGUST 17, 2004 BALTO, MARYLAND CALVIN B. SCRUGGS FUNERAL HOME	rematory or other place) CEMETERY 22. Name and Address of 8	mT. ZION	ecify) / //	2 Cremation 3 5 Other (Spe	1 ☑Burial 2 `4☑Donation		Department of He important: if Iter any injury or oth once.	battimore, IV permit. Pages 1 and Department of Health important: if item?				
The control of the	cardiac or respiratory arrest, Approximate	enter the mode of dying, such	used the death. Do not on the chine.	a. Con Due to (a	e (Final tion n) conditions, immediate derlying or injury	Immediate Cause disease or conditi resulting in death; Sequentially list of if any, leading to icause. Enter Und Cause (Disease of	ıminer	Pnysician /Medical Examiner					
Column C	·		orne of pregnancy	d. 23c. If yes, outco	ent pregnant	IF FEMALE: 23b. Was decede	lan/Medical Ex	ttending physicien ar or use as the burial-t	Sox 68760, ath certificate be exe				
Column C	23a Did tobacco use contribute to the cause of death?		√n	9□ Unknov	wn	9 Unknow	Physic	d by the a	P.O. I				
Column C		ase	las D'Se	1 Vasci	phera	Pen	ted by	en signe ould be d	ords,				
This plane is a state of the control	autopsy prior to completion of cause of death?				/	V	Comple	ate h page	m a				
The state of the s		3.4 Other	nationt 2 TER/Outpat	Hospital:	. /	examiner?	00	certifi					
The part of the pa	28d. Describe how injury occurred	of 28c. Injury at Work?	Injury 28b. Time	28a. Date of (Month	eath 5 Pending	27. Manner of Dea	 	h. After this funeral d					
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of Control one) 29d. Date signed (Month, Date of Control one) 29d. Date signed (Month, Date of Control one)	28f. Location (Street and Number or Rural Route Number, City or Town, State)	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
29b. Signature and title of certifier 29c. License number D 35082 29d. Date signed (Month, Date of Section 1)	d place, and due to the cause(s) and manner as stated. h occurred at the time, date and place, and due to the cause(s)	ath occurred at the time, da investigation, in my opinior	sis of examination and/or	xaminer: On the bas	1 Certifying 2 Medical Ex	(Chack only		n 24 hours ne Funera	ne Hospite				
On Name and address of passes who completed easing of death (from 22a) (Tupo Brist)	29d. Date signed (Month, Day, Year) 8/12/04			lms.	and title of certifier	29b. Signature an		To the comp	Toth				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 232 3 Over 1 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	224	e, Print)	Baltin	us st,	orlean	2323		2					

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

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			for State Registrar	Otate of W		rtificate of			og. No.2 () ()		25586
	g		Decedent's Name (First, Middle, Landson L	ast)				2. Date of Deat	h		3. Time of Death
	Physici /Medic		Ruth	М.	O'Don	ne11		Month August		Year 004	10:50 a ^M
	Examin		4a. Facility Name (If not institution, gi				r Location of Death		4c. County o		10.50 4
			Millennium Sout	h River		Edgewa	ater		Anne A	Arund	e1
	Funeral		*		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ce (State or Foreign
	Director		377 20 1015	1□M 2∏F	95 Yrs.				1909	Wash	ington DC
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				100	I. Inside City Limits
	danyl f sho	ច	MD Anne Aı	rundel	Edgewat	er					1 ☐ Yes 2 X No
	28a-	rect	10e. Street and Number		Lagewat	10f. Zip Code		10	Og. Citizen of Wi	hat Countr	/?
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show lical Examinat hual be multifud at	Funeral Director	121 Stewart Driv	7e		2103	3.7		USA	Δ	
	ms 2	era	11. Marital Status	12, Was Deceden	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-	14. Race	- American	
9	after or Ite		1 Never Married 2 Married	Armed Forces 1 Tyes 27 If Yes, Give		iryes, speciny Cuba 1 □ Yes 2 % O ∛No	an, Mexican, Puerto	Hican, etc.)	Į.	, White, etc	
21215-0036	rel,	d by	3X Widowed 4 □ Divorced	Year or Dates:		1 1 1 65 ZAZNAO	зреспу.		Specify:	Whit	e
5-0	72 h 'natu	etec	15. Decedent's E (Specify only highest gi		(Give	dent's Usual Occup kind of work done	during most of worki	ing	16b. Kind of Bus	iness/Indu	stry
121	vithin ne. hen	шb	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired etary	a)		U.S. Go		
7	Hygie Hygie ther t	Be Completed	17. Father's Name (First, Middle, Las	:t)	Dec.1	ecary	18. Mother's Name	(First, Middle, N			шепс
au	d be to	Be	Frank Duvall	,			Dora K			,	
Maryland	should Me mark matic	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura		City or Town, S	itate, Zip C	ode)
N	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. item 27 is marked other then "neturel", or Items 23a or 28a-f show other treumatic event, Ire M. dical Evarifier mast be notified at		Terry O'Donnell	(Granddau	ghter) 1222	Seminole	e Drive, A	rnold 1	MD 21012	2	
ē,	s 1 a f Hea item othe		20a. Method of Disposition		20b. Place of Dispo		1		20c. Location - C		n, State
Ë	Pages lent of nt: If i		1 XBurial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		•		ery 8/13/	2004	Suitland	i. MD	
altimore,	permit. Pages Department of Importent: If i any injury or one		21. Signature of Funer L Service 10	ensee	22	2. Name and Addre	ss of Facility Funeral F				
m	8 2 2 3		1000			12 Ridgel	Ly Avenue,	Annapo	lis, MD	2140	1
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that cause y one cause on fach	ed the death. Do not en	ter the mode of dyin	ng, such as cardiac o	or respiratory arre	est,	Ir	pproximate iterval Between
	Pnysician		Immediate Cause (Final disease or condition	. De	meutia						Inset and Death
	/Medical Examiner		resulting in death)	Due to a ra	s a consequence of):	> 01.					
	LAMITHICI	L	Sequentially list conditions,	b. 44	euclas de la constancia	Doblu	4				
	ed sit	lne	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Lucio (or a	a id sucreaeujaransid deji		1				
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequence of):						
'60,	sician sician burial	al E									
189	eath certificate b attending physic I for use as the b	edlo		0.							
Вох	h cert andin use	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		Ectopic pregnancy	,			of delivery	
	0 0 0	SICIA	in the past 12 months?			Other (specify)			Mont	h D	ay Year
P.0	that the deed by the detached	Physician/Medi	9 Unknowń								
	Se 150	by	Part II. Other significant conditions		Trive .	inderlying cause giv	en in Part I.		acco use contrib s 2 □ No 3		1.7
orc	w require been si should l	ted	- value	100	Milwe -						T CHRISTI
Vital Records,	law as b	Completed						24a. Was ar autops perform	/ pri	ere autops ior to comp ath?	y findings available letion of cause of
alF	i cien: The certificate h rector, page							1 ☐ Yes 2	10	Yes 2	□ No
Vit		o Be	25. Was case referred to medical examiner? 1 Yes 2 Mo	Hospital:		oth Oth	26. Place of Death			40 41	
of	Physic rubis stal di	I ⊢ I	27. Manger of Death	1 ☐ Inpat	ury 28b. Time o			me 5 Reside 28d. Describe ho			
ion	Attending I r death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(<i>Month, D</i> on	ay Year) Injury		rk? Yes 2⊡No				
Division	Attendi er death. ector: A by the fu	iffica	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 28e. Place of It	njury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number	or Rural F	Route Number,
Ö	tel or rs afte el Dir ed in	Certification:		Jonaing, C							
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	ledical	29a. Certifier (Check only one) 1 Certifying F	Physician: To the bes aminer: On the basis and manner s	t of my knowledge, deat of examination and/or in tated.	h occurred at the tir vestigation, in my o	me, date and place, a ppinion, death occurr	and due to the ca ed at the time, da	use(s) and man ite and place, ar	ner as state nd due to th	ed. ne cause(s)
	fo the within 2 fo the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed	(Month, Da	y, Year)
	. >=0					Т	057020		08-11-	-04	
	Ü		30. Name and address of person who	o completed cause of	death (Item 23a) (Type,	Print)	1000				
_	1		ADITY A CHOP		DO Plage	Ly Ave S	tc. 231 A	nnapdi	S,UD.	2141	
:	Sta Regist	ate rar	31. Date filed Worth, Day, 2004	32. Regis	trar's Signature	Dorkal		-	•		
	riegisi	111			1						

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedant's Nama (First, Middle, Last) Yaar **Physician** 11, August Dorothu M. Popp 2004 9:30 PM /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Manor Care Nursing Home - Rossville Rossville Baltimore If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Oct. 7, 19 Birthplaca (Stata or Foreign Country) 5. Social Security Number 6. Sax Funeral Days Months 1 □ M 2 □ F 79 1924 Maryland Director 219-10-0210 Usual Residence of Dacedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yas 2 ☑ No Director Maryland Baltimore Baltimore 10g. Citizan of What Country? 10f. Zip Code 10e. Street and Number 533 Holly Hunt Road 21220 U.S.A. 12. Was Dacedant Evar in U.S. Armed Forces? Was Dacedent of Hispanic Origin? (Spacify Yas or No-tf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give Yaar or Datas: 1 Navar Marriad 2 Married 219 10-0310 D65.1 1 ☐ Yes 2 No Spacify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decadant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education
(Specify only highast grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Haalth and Mantal Hygiene. Important: If item 27 is marked other than ' Elamantary/Secondary (0-12) College (1-4or 5+) Homemaker 8th Grade Own Home. 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Edward Deegan Margaret Smith 19b. Mailing Addrass (Straat and Numbar or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typa, Print) Mrs. Betty M. Wenger (daughter) 533 Holly Hunt Road, Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 Denial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 8/16/04 Baltimore, Maryland 22. Name and Address of Facility Schimunek Function Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the diseasa, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disaase or condition rasulting in death) /Medical Examiner Certification: To Be Completed by Physician/Medical Examiner Attanding Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco usa contribute to the causa of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SERSIS 24b. Wera autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was casa refarred to medical axaminar? 26. Placa of Death (Chack only one) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Director: After this in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Atlaturat 5 Pending 1 Yes 2 No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not ba determined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide 24 hours 124 Certifying Physician: To the best of my knowledge, daath occurrad at the time, date and place, and due to the cause(s) and manner as statad. Medical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D55306 Dedie K. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 PHILADEPHIA BD SOUTE 200 BALTO. MD 21237 DENNIS HICOLE MD 32. Registrar's Signatura 31. Date fited (Month, Day, Year) State AUG 1 3 2004 Registrar

9.30 pm

			Amend 1 = For State Registrar	State of Ma	r fh g845 Tryland Depa Ce	7-18- artment rtificate			ınd M		giene Reg. No	01.	25500
	Physici	20	1. Decedent's Name (First, Middle, Last)							2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Dorothy Evelyn Pr		· · · · · · · · · · · · · · · · · · ·					August		2004	03:15 ^{ат} м
	Examir	er	4a. Facility Name (If not institution, give					Location of	f Death			ty of Death	
			Charlestown Care		. (In one In at hinth day)	Cato:		lle If Under 2	24 Live	0.00		imore	
	Funeral Director		5. Social Security Number 6. Security Number 214-16-3397	м 2 // X	e (In yrs. last birthday) 81 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da)	y, Year)		place (State or Foreign ntry)
			Usual Residence of Decedent		0.2	1				May 2,	1923	Mar	yland
	72 hours alter death with the Maryland natural; or Hams 23a or 28a-f show Jisal Ezanaher must be notified at		10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits
	a-fs	ctor	Maryland Baltimor	e	Catonsvil	1e							1 □ Yes 2 No
	or 28	Directo	10e. Street and Number			10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	23a	rai	707 Maiden Choice	Lane, Apt	. 7315	212	28				U.S.A.		
	tams	Funerai	11. Marital Status	12. Was Decedent I Armed Forces? 1 □ Yes 2XX	Ever in U.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Orig	gin? (Spe , Puerto	city Yes or No- Rican, etc.)	- 14. Ra Bla	ice - Ameri ack, White,	
36	or l	by Fi	1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	lo l	1 Yes 2	XX _{No}	Specify:			Speci	ity: Whi	te
8	tural al Ex		15. Decedent's Edu	Year or Dates:	16a Deco	dent's Usua	Cocupa	tion			16h Kind of I	Duaine en/la	adventur.
i S	in 72 " na Redic	ojet	(Specify only highest grad	e completed)	(Give	kind of wor DO NOT us	k done d	urina most	of worki	ing	16b. Kind of E	545111855/11	laustry
7	within items.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Execu	tive	Secr	etary	,		Johns	Hopki	ns Univ.
ਰੂ	ould be tiled within 72 hours after death with the Marylan Mental Hygiene. arked other than "natural; or Itams 23a or 28a-f show aire avent, the Medical Expraîner must be notified at	BeC	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden Suma	me)	
<u>a</u>	should be nd Mental markad matic av	ToE	Camillo Vanni					Mari	e Di	.Giovanr	ni		
a	S D E E		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address	(Street a	nd Numbe	r or Rura	I Route Numbe	r, City or Towr	, State, Zij	Code)
Σ	로 5 분 로		William Otto Carl	Prinke(h			NAME OF TAXABLE PARTY.	Choic	e La	ine, Apt			
ore			20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Place of Dispo	matory or of	ne of ther place)		ate	20c. Location	- City or T	own, State 21228
Ē	Pagas ment of lant: If it		* 4 ☐ Donation 5 ☐ Other (Specify)		Dulaney V	alley			8-12	-2004	imoniu	m, MD	
Baltimore, Maryland 21215-0036	permit. Paga Department of Important: If any injury or once.		21. Signature of lineral service Licens		Memorial W	itzke	Fun	s of Facility era1	, Home	of Cat	onsvil	le, I	nc.
	TO 2 6 0		23a. Part1. Enter the disease, or compl	M012						ue, Cat		le, M	D 21228 Approximate Interval Between
	we be executed /Medical /Medical /Medical examiner and purial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of): a consequence of): a consequence of):	Pen	1017	14					
.O. Box 68	The law requires that the death certificate be executed the been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pre						ate of delive	ery Day Year
rds, P.	w requires that been signed I should be det	b	Part II. Other significant conditions con	ntributing to death b		nderlying ca	ause give	n in Part I.		23e. Did to	4		he cause of death? Dably 4 Unknown
Vital Records,		Completed										Were auto prior to co death? 1 \(\subseteq Yes	psy findings available impletion of cause of
'Ita	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only o			
<u>o</u>	G S X	၉	1 ☐ Yes 2 Ø No	lospital: 1 🗌 Inpatie				4 A Nur	rsing Hor	me 5 ☐ Resid	lence 6 🗆 Ot	her (Specif	y)
Division	Jing After fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da	ry 28b. Time o (Year) Injury	f 21	8c. Injury Work 1 □ Y	at ? ′es 2 □ N	No .	28d. Describe h			
Divi	or A atter Dire in b		4 Homicide determined	building, et						City or Tow	m, State)		al Route Number,
	To the Hospital within 24 hours and to the Funaral completely filled	ledical	one) 2 Medicel Exemi	sicien: To the best ner: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	vestigation,	in my op	inion, deat	d place, a	and due to the dead at the time, d	cause(s) and m date and place,	anner as s , and due to	tated. o the cause(s)
1	V Viit	Σ	29b. Signature and title of certifier	m MA		Da	License	040			29d. Date signs	104	Day, Year)
1	1-1		30. Name and address of person who co	ompleted cause of d	eath (Item 23a)*(Type.	Print)	lio	ice	Ca	ue, c	Calon	inll	1 MA
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	,							420

DHMH 17 Rev 1/2001

ORIGINAL

10 sports

		1	FOR	artment of Health and Ment	al Hygien	2001 2000
			Decedent's Name (First, Middle, Last)	2. Da	ate of Death	3. Time of Death
	Physicia		Joseph Leo Poole	AL	onth Da	13 2004 2:00A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
		•	1625 Lakewood Road	Pasadena		Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs. 8. Do (A) Months Days Hours Min. 1 O /	ate of Birth Month, Day, Year 04/191	9. Birthplace (State or Foreign Country) MD
	р	h	Usual Residence of Decedent			10d. Inside City Limits
	arylar show	_				1 ☐ Yes 2 No
	8e-f	Director	MD Anne Arundel Pasader	na 10f. Zip Code	100.0	Citizen of What Country?
	with ti		10e. Street and Number	21122		U.S.A.
	s 23	erai	1625 Lakewood Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify.)	res or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural, or Items 23a or 28e-f show importent: If item 27 is marked other than "natural, or Items 23a or 28e-f show importent; If item 27 is marked other than 12 in Maryland Example Indifficit at 1000.	by Funeral	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced Amed Forces? 1 Yes 2 No 1941 - If Yes, Give Year or Dates: 1945	If Yes, specify Cuban, Mexican, Puerto Rican 1 ☐ Yes 2 1 No Specify:	n, etc.)	Black, White, etc. Specify: White
Maryland 21215-0036	hour tural		15. Decedent's Education 16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry
5	in 72 n "na	Completed	(Specify only highest grade completed) (Give	e kind of work done during most of working DO NOT use retired)		
212	with giene r tha	ШО		chanic		Automotive
ğ	al Hygie other	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		
<u>a</u>	should be ind Mental smarked o umatic eve	70	Frederick Poole	Theresa		
an	2 sho and I is mu			ling Address (Street and Number or Rural Rou		
	and health m 27		Trace galact color,	5 Lakewood Rd., Proposition (Name of Date		Location - City or Town, State
Baltimore,	Pages 1 nent of He ant: If iter ury or oth			ematory or other place)		
Ë	t. Partmen			w Crematory 08/13		
Bal	permit. Departi		Sul Jon 1	22. Name and Address of Facility GJ G 69 Riviera Dr., P	asaden	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or res	piratory arrest,	Approximate Interval Between Onset and Death
þ	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. RENAL FA Due to (or as a consequence of):	ILURE	 -	Oriset and Death
	Examiner					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.			
Ó,	e exe ian ar urial-t		resulting in death) Last Due to (or as a consequence of):			
8760,	ate by hysic the bi	lica	d			
9	entific ling p	Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy		Month Day Year
	that the de	ysic	1 Yes 2 No 9 Unknown	and the compy		
P.0	res that t signed by be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
sp.	puires n sign	d by	CONGESTINE MEANT FAILL	PE	1 🗌 Yes	2 No 3 Probably 4 Winkhown
Vital Records,	The law requires that the tte has been signed by th page 2 should be detache	Completed	CHAONIC OBSTAUCTIVE PLUMEN	LARY DISEASE	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Re	The lavate has	E O			performed? 1 ☐ Yes 2 ☐ →	death?
tal		(a)	25. Was case reterred to medical	26. Place of Death (Ch	eck only one)	
₹ V	ys Si	To B	examiner? 1 Yes 2 Mo	ent 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐Other (Specify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	/ Work?	Describe how in	jury occurred
<u>Sio</u>	Attending ir death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No		and Number or Rural Route Number,
Division	of or Attend after death Director:	Certification:	3 Suicide 4 Homicide Suicide 4 Homicide Suicide Suici	street, factory, office	City or Town, Sta	ate)
	ospitei hours a uneral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, and p	due to the cause	(s) and manner as stated.
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, de caminer: On the bast of examination and/or and manner stated.	investigation, in my opinion, death occurred at	t the time, date a	and place, and due to the cause(s)
	To the Hi within 24 To the Formplete	Me	29h Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
-	F ₹ F 8		manino mo	D57531	AL	igust 13, 2004
6	MI	1	30. Name and address of Jesson who completed cause of death (Item 23a) (Typ	e, Print)		
: 70			Mohit Negi, 8601 Veteran	D57531 s Huy, Millessis L	Len	1921108
	St	ate	21 Date filed (Month 1)av Year) 32. Hedistrat S Signature			
	Regis	trar	AUG 1 3 2004 Sentira 14	Locato!		
D	HMH 17 Rev 1/	2001		/		

DHMH 17 Rev 1/2001

ORIGINAL

		-	1 - For State Registrar	State of Ma	-	epartment of l Certificate of		F	Reg. No. 0 0	25590	
ı	Physici /Medic	an	Decedent's Name (First, Middle, Las JAMES EDWARD	PIERCE				2. Date of Dea Month AUGUST	Day Year	3. Time of Death 2:55 P M	
	Examin		4a. Facility Name (If not institution, give MARYLAND HOUSE		CTIONS		or Location of Death		4c. County of De		
	Funeral Director			7. Age	e (In yrs. last birth 48 Y	day) If Under 1 Year Months Days		8. Date of Birt (Month, Da) 08/03/	1956 MA	lirthplace (State or Foreign Country) RYLAND	
036	aryland show		Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. City, Town	or Location BALTIMOR	E CTTV			10d. Inside City Limits Yang Yes 2 No	
	with the M e or 28a-f Le notifie	Funeral Director	10e. Street and Number 634 MC COLLOUGH CI	RCLE		10f. Zip Code 2120			10g. Citizen of What (
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or Items 23e or 28e-f show entry injury or other treumatic event, it is Marical Exaction trained to another. Once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:		if Yes, specify Cut	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:			nerican Indian, nite, etc. BLACK	
21215-0036	within 72 ho ane. then "netu	Completed	15. Decedent's Ed (Specify only highest gra		16a. [(i+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire LABORER	pation during most of work ed)	king	16b. Kind of Busines	es/Industry EMPLOYED	
	id be filed ental Hygis ked other fc event, II	To Be Co	17. Father's Name (First, Middle, Last) JAMES RICHAR		ne (First, Middle, SE JOHN	Maiden Sumame)					
Maryland	nd 2 shou alth and M 27 is mar or treumat	þæ !	19a. Informant's Name/Relationship (7 LOUISE DORSEY /			Mailing Address (Stree			-		
Baltimore,	Pages 1 a nent of Hei ant: ff item ary or othe		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery	Disposition (Name of crematory or other place CREMATORY	ice)	Date /2004	20c. Location - City of BALTIMORE		
Balt	permit. Departr Importe eny inji		21. Signatu Fu eral Service Licen	MA	our	4600 LIB	ERTY HEIGH	HTS AVE,	VERAL HOME BALTIMORI	E, MD 21207	
68760,0	Provided by the provided by the private of the priv	dical Examiner	23a April Effer the disease, or compension, or heart fature. List only immediate Curse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the Underlying Cause) Disease of the Underlying Cause (Disease of the Underlying Cause) Disease of the Underlying Cause (Disease of the Underlying Cause) Disease of the Underlying Cause (Disease of the Underlying Cause) Disease of the Underlying Cause (Disease) of the Underlying (Disease) of the Un	a. Due to (or as b. Due to (or as c. Due to (or as	a consequence of	incer sistoth muffi	e Spir		-	Interval Between Onset and Death	
P.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of d Month	delivery Day Year	
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	3		30. Name and address of person who	OHANNE	5, 8105		Y RUN R	d, JEI	rsup my	20794	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1. Anne			,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 59 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Kobbins illiam 2004 UG /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner TIMORE 100 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MARY AUA Security Number 7. Age (In yrs. last bjrthday) **Funeral** Days Hours Min 218-26-6937 Usual Residence of Deceded Yrs. Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show injury or other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Jan K Director BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number natural, or Items 23a Funerai 12. Was Decedent Ever in U.S. Anned Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commercial permit. Fages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other treumatic event." Elementary/Secondary (0-12) College (1-4or 5+) resident 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Be solonins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Kaintlower laine KODDINS WITE 0 Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bulancy Valley Men Gardens 8-13-C4 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nameland Andress of Facility 2000 Timonium mo 21093 21. Signatury of Funeral Service Li Simbelle PEACEFUL ALTERNATIVES FUNERAL-CREMATION CTE Approximate Interval Between Onset and Death ons that caus to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, shock, or heart ailure. L Immediate Cause (Fin Ardionno pat **Physician** disease or condition resulting in death) /Medical Examiner NON ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of) of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetel dea 4 ☐ Pregnant at time of death 2 | Fetel death 3 Ectopic pregnancy in the past 12 months? Month Day Year should be detached for 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 NO 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 Der 1 ☐ Yes filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Division or Attending 5 ☐ Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 24 hours a 1 X Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical mpletely within 2 To the I

State Registrar 31. Date filed (Month, Day, Year) AUG 1 3 2004

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 233) (Type, Print)

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29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3 Time of Pleath **Physician** 2004 August 9:25 A M Angelina Reese /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Keswick 700 W. 40th Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-24-1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F 82 Yrs 168-14-5715 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryiand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or Items 23a or 28a-f show the Madical Examiner must be notified at 1 XYes 2 ☐ No Be Completed by Funeral Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40th Street 700 W. 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 3 Midowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 11 caretaker Healthcare 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If Item 27 is marked ott jury or other treumatic even ဂ္ Mary Lamahna Dominick Palumbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Daughter 3120 Grindon Ave Md. 21214 <u>KarenCalhoun</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【*Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Hilltop Service Corp. 8/13/04 Towson, Md 21204 21. Signature - Fundra Service Licentee 22. Name and Address of Facility 5305 Harford Road Balt. Md 21214 agan Leonard J. Ruck, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ancer **Physician** Uno months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy signed by the at d be detached for 5 Other (specify) 9 Unknown 9 HUnknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OSSTruction Pulmonty Disense Chroniz 12 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 2 No 1 Tyes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: 1 Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier wo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arle J. Balty- and 2120x 6-BINC 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2004 Registrar

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	Disconicio	_	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		2004	3. Time of Death	
	Physicia /Medic	al	T. Edgie Russell, Jr.			1	(D 1)	August	4c. County of		7:40 p м	
	Examin	er	4a. Facility Name (If not institution, give street and number) Masonic Health Center		4b. City, Town, or Cockeys				Balti		5	
			5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birtholi	ace (State or Foreign	
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	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.		
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B	al Hyg	Be C	17. Father's Name (First, Middle, Last)						Maiden Sumame,)		
yiand	ould to Ments Merskec markec	2	T. Edgie Russell		ng Address (Street a	Mina		euter	Character C	to to Zin	Codel	
Mar	12 sh hand 7 ism ireum		19a. Informant's Name/Relationship (Type, Print) Mrs. Donna Russell/ Wife		suckley Co					ate, Zip	C004)	
ض -	1 and Healt Iem 2	1	20b. Place of	of Dispo	osition (Name of matory or other place				20c. Location - C	ity or To	wn, State	
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Division of	or Attenditer death birector: A birector: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, st	-	195 2	1	28f. Location (S City or Tow	treet and Numbe n, State)	r or Rura	I Route Number,	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 6:00 A M 2004 August 10, Francis Joseph Rosenberger /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville Heart Homes If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 10XM 2□ F 95 10/17/1908 Maryland Director 224-60-1205 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rai', or itams 23a or 28a-f show Example at must be collified at 1 TYes 25 No Baltimore Lutherville Direct 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21093 U.S.A. 1414 Front Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Itar any injury or other traumatic event, Ita Medical Essina at once. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coltege (1-4or 5+) Elementary/Secondary (0-12) Auto Trimmer Federal Government 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eva Weise Joseph Rosenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 Briarcliff Road Baltimore, Maryland 21234 Mary De Baugh/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer 8/13/04 ' 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair koad Baltimore, Maryland 21206 23a. Part1. Enter the disease, or polications that ages of the Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (First disease or condition resulting in death) 304051 **Physician** 010101 arter Due to (or as a con equence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Ves 2 No 9 Unknown s been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred s after death. 27. Manner of Death 28c. Injury at Work? Injury 1 Matural 5 Pending 1 🗆 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0-050n MD 21204 T 001 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 3 2004

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Frank Schuller 725AM

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_		2	3a. Part1. Enter the disease, or	r complications that caus		iter the mode of dying, such as ca	ardiac or respiratory arres	t,	Approximate Interval Between
Physic	ian	In	nmediate Cause (Final	City one pause on each	Supply Cla	u con. 1	(00 10		Onset and Death
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ath cer	, i	23	Bb. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth		☐Ectopic pregnancy		23d. Date of de	
e dea		200	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of death 5	Other (specify)		Month	Day Year
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ding h	aun .	0 27	Manner of Death 1 □ Natural 5 □ Pendir		njury 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
Itand Itand Jeath Itor:	96	cat	2 Accident investi 3 Suicide 6 Could	not be		M 1 Yes 2 No		-4 1 41	15
or A or A or A or A	ya n	ertification;	4 Homicide determ	nined 286. Place of I building,	njury - At home, farm, st etc. <i>(Specify)</i>	геет, тастогу, опісв	City or Town,	et and Number or Ri State)	urai Houte Number,
pital purs e		ပ 🛌	ea. Certifier (Certifying	ng Physician: To the box	at of my knowledge, does	the annurand at the time date and	place and due to the sec	(-)	
To the Hospital or Attanding Physician: The law within 24 hours effer death.	eteiy	edical	(Check only 2 Medicel one)	Examiner: On the basis and manner:	of examination and/or in	th occurred at the time, date and nvestigation, in my opinion, death	occurred at the time, date	se(s) and manner as and place, and due	to the cause(s)
o the ithin o tha	duo	-	b. Signature and the of certifie			29c. License number	290	. Date signed (Mont	h, Day, Year)
⊢ ≩ <u>⊢</u>	0		> / las	7 mg		05-3115		well + at	
2 F		30). Name and address of person	who completed cause of	death (Item 23a) /Tune	Print)		7	0,00
ΙC)	30	Jeff Lond.	6600		Blud Parkul	le mo z	1234	
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DHMH 17 Rev 1/2001

Registrar

AUG 1 3 2004

			1 - For Stata Registrar	State of Marylan		artment o			, ,	iene		255	96
ſ	Physici		1. Decedent's Name (First, Middle, Last) John A. Schilpp						Date of Deat Month August	Day	Year 04	3. Time of 10:30	
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Tow	n, or Location		iugube -	4c. County		10.30	
	L. Adillii		1312 Scottsdale R	load, Unit C		Bel .	Air			На	rford	1	
	Funeral Director		5. Social Security Number 6. Sex 218-22-1144		ast birthday) Yrs.	If Under 1 Ye Months Da			Date of Birth (Month, Day, ec. 8,	1927	9. Birthp Cour Mary	olace (State o otry) 7 Land	r Foreign
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					1	0d. Inside Ci	tv Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Exerciting Instituted at once.	Director	Md. Harfor			l Air						1 🗌 Yes	
		ai Dire	1312 Scottsdale R	Road, Unit C		10f. Zip Coo	¹⁰ 21014		10	10g. Citizen of What Country? United States			
920	urs after deal al', or Itams (Examément	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U. Armed Forces? I ⊠Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent f Yes, specify C □ Yes 2⊠			Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: white			
215-0	hin 72 ho in natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	lent's Usual Ockind of work do	ne durina mos	st of working		6b. Kind of Bu	isiness/Ind	dustry	
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land	ld ba file ental Hy kad oth ic evant	To Be (17. Father's Name (First, Middle, Last) Frederick Schilpp	1				er's Name <i>(F.</i> 1a Geor		laiden Sumam	ie)		
Mary	d 2 shou th and M 27 Is mar traumati	-	19a. Informant's Name/Relationship (Type Marquerite Hyman/	ое, Print)		g Address (Str						Code)	
Baltimore, Maryland 21215-0036	ages 1 ar int of Heal t: If itam 2 y or othar		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State	emetery, cren	sition (Name or natory or other S Ch. (place)	Date 8/14/0	3.	Hydes,		wn, State	
Baltir	permit. P Departme Importan any injur.		21. Signature of Funeral Service License			Name and Ac Schimu	1					inc.	
	-		23a. Part1. Enter the disease, or complic	cations that caused the death	. Do not ente	610 W.	MacPha	ail Roa	ad, Bel	Air,	Md. 2	1014 Approximate	9
	Pnysician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.		INF						Onset and D	ween Death
	Examiner		Sequentially list conditions.		ience of):								
	cuted od ransit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):									
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.O. Box	ne death certificate be executed the attending physician and thed for usa as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregna Other (specify		23d. Date of delive Month					/ear
Δ.	uires that the de signed by the d be detached	by	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause	given in Part	1.	23e. Did tob	acco use conti	ibute to th		
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/ita	iclan: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					e of Death (C	heck only one)			
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O	ding After fune	tion	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury		njury at Work? 1 □ Yes 2 □		. Describe no	w injury occurr	9U		
Division of	l or Attendi after death. Diractor: A I in by the fu	27. Many of Death Yes 2 No								28f. Location (Street and Number or Rural Route Nu City or Town, State)			<i>3er</i> ,
	Hospita 4 hours Funeral ely fillec	edical C	29a. Certifier 1 Certifying Physics (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the	e time, date ar ny opinion, dea	nd place, and ath occurred a	due to the ca at the time, da	use(s) and ma te and place, a	nner as stand due to	ated. the cause(s)	
	To the within 2.	Me	29b Signature and title of certifier	ind	ms	29c. Lic	ense number	75	29	d. Date signed	(Month, L	Day, Year)	24
ĺ	04/2	/	30 Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print) 2//	2 30	ZAIR	- Ru	AD.		100	,
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	FIFU	STUN	<i>/ / / / / / / / / /</i>	Arcy	-HWD	Ø	404	
	Registr	ar	AUG 1 3 2004	Older De 1	September 1	•							

John A, Schilpp 8-10-04 109m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2004 tugust se ID. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rossville Genesis Eldercare-Franklin Woods Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
April 26, 1908 New York 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🔀 F 96 212-18-5633 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic evant, the Madical Examinist must be notified at once. 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Maryland | Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21234 u.s.A. 129 E. Orange Ct. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specity: Completed by 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 E. Orange Ct., Baltimore, MD 21234 Mrs. Elaine Robbins (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Moreland Mem'l Park 8/14/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Brin Ce. Ullle 9705 Belair Rd., Baltimore, MD 21236 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence ol): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examiner law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physicien Completed by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 70 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Certification: 1 Natural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 2 ☐ Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) determined filled in by 4 | Homicide after within 24 hours a To the Funeral C the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

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altimore, Maryland 21215-0036

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Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CMD

32. Registrar's S

Edmordon MD

		State of Maryland / Department		lental Hygi	iene	
		Registrar CETITICALE	e of Death		g. No. 1	25598
Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	9. Time of Death
/Media	cal	Loretta M. Sanzone	Town and position of Doub	August	10 2004	0545 AM
Examir	ner		Town, or Location of Death		Bo 1	- 0
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under	204 - 1	8. Date of Birth		more (State or Foreign
Funeral Director		217-20-3471 1 M 2 F 78 Yrs. Months	Days Hours Min.	(Month, Day,	1.1926 Penn	intry)
		Usual Residence of Decedent		July 10	7,1720 1 6747	sycourrea
arylan ahow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
e Ma Ba-fa	cto	Maryland Baltimore Baltimor	re			1 ☐ Yes 2 No
or 28	Director	10e. Street and Number	Code	10	g. Citizen of What Cor	intry?
ath w	ra	7 A Raylon Drive	21236		u.s.A.	
er de tams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specific Y	ent of Hispanic Origin? (Spe ify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo 3 ☐ XWidowed 4 ☐ Divorced Year or Dates:	No Specify:		Specify: Whi	te.
be filed within 72 hours after death with the Maryland lat Hygiene. Ital Hygiene. Id other then "naturel", or Itams 23e or 28e-1 ehow event, the Medical Exeminar must be notified at	ed	15, Decedent's Education 16a. Decedent's Usual	Occupation	1	6b. Kind of Business/I	ndustry
n 72 oil	Completed		k done during most of worki	ing		, addition, and a second
d with giene r tha	mo:	12th Grade Office Wor	rker		Insurance	
othe vant,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	faiden Sumame)	
uld b Ments rrkad rric a	To	Stephen Gregor	Wanda	Bartose	vich	
2 should and Men Is marka			(Street and Number or Rura			
and and and n 27			tts Haven Dr.			
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State	ne of their place)	Date 2	20c. Location - City or 1	own, State
rmit. Pages partment of portant: If it y injury or c		4 Donation 5 DOther (Specify) Gardens of Fai	th 8/13	/2004 B	altimore,	Maryland
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40280			lelair Rd., B			
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deati deatite ad for	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (spe			Month	Day Year
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law ras be	ηple	hapentension		24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
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nding Physician: th. T. After this certifica e funeral director, p	ertification:	1 Natural 5 Pending (Month, Day Year) Injury	Bc. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe hov	w injury occurred	
Wttandii death. ctor: A y the fu	licat	2 Could not be		28f Location (Stre	eet and Number or Rur	al Route Number
lor Atta after dea Diracto	erti	4 Homicide determined	5.1100	City or Town,		ar reaco rearrison,
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	alc	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred a	at the time, date and place,	and due to the cau	use(s) and manner as:	stated.
e Ho 24 h a Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	in my opinion, death occurre	ed at the time, dat	te and place, and due	o the cause(s)
To th Mithin To th	¥,		License number		d. Date signed (Month,	
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11/1		3. Varie and a Liteus of Jerson who completed cause of doath (Item 23a) (Type Print)	,	900	0 Franklin	Sq. Un.
10		ANDREW I. BUKOVITZ M.D. FRA	OOS1438	Hosp. hal	Balt., MD	21237
	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature	·	,		
Regist	rar	AUG 13 2004 Kinger & Speciel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State RegistrarAMEND ITEM #12 PER FH C834 8 PETYTEA at 9H of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 715 PM 204 Shields Jr OU, Preston 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HEALTHCARE AGNES BALT MORE SAINT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) XIXM 2□ F Yrs. 16 06 NC 216-42-4860 58 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 21216 U.S.A. 2114 Allendale Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 X eo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married XX Married 1 ☐ Yes XXNo Specify 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed 9th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Preston Shields Sr. Charity Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2114 Allendale Road, Baltimore, Md 21216 Jessie Shields-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ¶urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet. 8/16/04 Owings Mills, Md of Funeral Service Ligense 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tas-Ta a. 00 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked other any injury or other treumatic event, once.

Physician

/Medical

Examiner

Funeral

Director

show

il Hygiene. other then "natural", or ftems 23e or 28e-f shov vent, lite Modical Experience must be notified at

Funeral Director

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Completed

with the Maryland

death

filed within 72 hours after

21215-0036

altimore, Maryland

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physician a s the burialthe a þ certificate has After this de ath. the Director:

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Medicai

State

Registrar

Examiner Physician/Medicai Completed Be 2 Certifidation:

3 Suicide

29a. Certifier

4 Homicide

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

Could not be determined

28a. Date of Injury (Month, Day Yeer) 5 Pending investigation

Hospital: 1 ☐ Inpatient

2 ER/Outpatient 3 DOA 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

my eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who come

. Date filed (Month, Day, Year, AUG 1 3 2004

nde 32. Registrar's Signature

Hospitel or Att

within 24 hours a

			Please		nt in Black In				_	
			1 - For State	State of M	aryland / Depa	artment of I <i>rtificate of</i>			0 0	00000
			1. Decedent's Name (First, Middle, La	est)		Tillicale UI	Dealli	2. Date of Dea	Reg. No	3. Time of Death
	Physici /Medi		Alfred	Т.	Sorace			10, 2004 Yea		
1	Exami		4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of De	
			Glen Meadows 5. Social Security Number 6.	Sex 7. Ag	ge (In yrs. last birthday)	Glen /		0.0-1- (0:4)	Balt	imore
	Funeral Director		114-12-7862	ÌÒ M 2□F	92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day March 2	r, Year)	Birthplace (State or Foreign Country) New York
	D >		Usual Residence of Decedent					I I CIT Z	J,1912 1	
	death with the Maryland ms 23a or 28e-f show rmust be notified at	ō			10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ YNo
	r 28e-	Director	Maryland Baltim 10e. Street and Number	ore	Glen A	10f. Zip Code			10g. Citizen of What	
	th with	al D	11630 Glen Arm R	oad		21057	7		ΠSΔ	
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)		merican Indian, hite, etc.
36	to of	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	If Yes, Give 1 Year or Dates	No 943-1946	1 ☐ Yes 2 💢 No	Specify:		Specify:	Mhite
2-0	72 hours natural', Jical Exp	ted	15. Decedent's E	ducation	16a, Dece	dent's Usual Occup	pation	ina	16b. Kind of Busines	
121	E	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		during most of work d)	arig		
d 2	be filed within tal Hygiene. Ind other then event, Ire M	e Co	17. Father's Name (First, Middle, Lasi	·)	Sa	alesman	18. Mother's Nam	e /First Middle	Shoe	
an	a a a	To B	Michael A.	Sorace			Conche		Megna	
Maryland 21215-0036	2 should be and Mental is marked (raumatic ev	8	19a. Informant's Name/Relationship			ng Address (Street			r, City or Town, State	, Zip Code)
	and sealth m 27	1 3	James_Sorace	Son	8620 20b. Place of Dispo	Valleyfi	eld Road_	Luther	ville, Mar	yland 21093
nor	ages nt of h t: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □		cemetery, crer	natory`or other pla	ce)	Date	20c. Location - City of	or Town, State
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke any injury or other traumatic <u>pnce</u> .		'4 □Donation '5 □ Other (Speci	••	HIIITOD S	Name and Addre	orp. 8-11		Towson	Maryland
ä	permi Depa impo any is		* taul latte	Man		.050 York	Nu	owson.	on Funeral Marviand 2	Home, Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	on cause on each li	d the death. Do not ent	er the mode of dyir				Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition resulting in death)	a. CA	RCINUI	nA OF	= 1 HB	LUN	6	Onset and Death
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Ur	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
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687	tificate g phys as the	edlc								
Box	The law requires that the death certificate I tel has been signed by the attending physioage 2 should be detached for use as the I	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy	,		23d. Date of de	elivery
	e deal the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown		Other (specify)	<u>'</u>		Month	Day Year
P.O.	w requires that the de been signed by the should be detached	/ Ph	Part II. Other significant conditions	contributing to death b	out not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
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900	law re as bee 2 sho	Completed by	C.O.P.D. B	BENICH	PROSTATI	C HYP	ERPLAS!	24a. Was a autops	n 24b. Were a	autopsy findings available completion of cause of
Ä		Com	/		1 1) = (3				med? death?	
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death			
of	> 00	. To	1 Yes 2 No	1 ☐ Inpatie 28a. Date of Inju (Month, Da		3 DOA	4 Zaursing Ho		ence 6 Other (Special Control of the	ecify)
ion	Attending r death. ector: After by the fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio		y Ye <i>ar)</i> Injury	28c. Injun World M 1 🗆	k? Yes 2 □ No		,.,	
Division of Vital Records,	r Atte ter de irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Inj building, et	ury - At home, farm, stre c. (Specify)	et, factory, office	0.000	28f. Location (St. City or Town	reet and Number or P n, State)	Rural Route Number,
Ω	To the Hospitel or Attending Ph. within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.		29a. Certifier 1X Certifying Pt	voicion. To the boot	at any transmission of the state of the stat		1			
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	To th To th comp	Me	29b. Signature and title of certifier	D	^	29c. Licensi	e number	2	9d. Date signed (Mon	th, Day, Year)
	<i>i</i> 1			KAMA	NAGORALA	n D 5	1228		8/11/8	004
	W71		30. Name and address of person who	eempleted cause of d	leath (Item 23a) (Type, I	F. Ro	LLING (ROSSRO	AAS #150	MD2,220
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	1		, - 1		11 1/2 1/2 1/28
	Registr	ar	AUG 1 3 2004	Seren	a B	doorte	Sy			

AUG 1 3 2004

Spales

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month August 7, 2004 **Physician** Mary Ruth Smith 6:10am M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. 04/02/1921 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** 1 □ M 2 ₩ F 83 219 86 3062 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits MD Baltimore 1 ☐ Yes 2 ☐ No Be Completed by Funeral Director Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8114 Sumter Avenue 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. Yes 20 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify: Specify: White 3√Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Alexander Kurisch Anna Telelaski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barrett Smith Jr. SON 562 Anchor Dr. Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith 08/11/04 Raspeburg `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Cvach/Rosedale Funeral Home +1211 Chesaco Avenue Rosedale Maryland 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive heart failure Ejechon Fraction 20%/3 Immediate Cause (Final disease or condition resulting in death) **Physician** 2 years /Medical **Examiner** Due to (or as a consequence of): Syears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 27 No Certification; To filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of after death. 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Bonnel Cohon MI 041797 8/1/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7/41 Security Blu Bulhinge MD 21244 BOARIE COHER MID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 3 2004

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 5:30 **Physician** m of August 10 2004 Doris E. Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11208 Thompson Ave. Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year! March 6, 19 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🕱 F 213-26-6765 76 Director Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a State "natural", or Itams 23a or 28e-f shov adical Examinar must be notiffied at 1 TYes 2 No Director Baltimore Reisterstown Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with 11208 Thompson Ave. 21136 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify If Yes, Give Year or Dates: White 3 ♥ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
7 Is marked other than "natur traumatic avant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) L.P.N. Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vera T. Dell Frank Brooke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Importent: If itam 27 Is any injury or other tra 661 Ridge Rd. Westminster, Md. 21157 JoAnn Lopez - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Deer Park Church Cem. Aug. 13,2004 Reisterstown, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee 11605 Reisterstown Rd. Owings Mills, Md. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician TOU disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit certificate be executed that initiated events resulting in death) Last the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 Z No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatrent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Tes 2 No ^D this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After a Hospitel or Attanding I 24 hours after death. e Funarel Diractor; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To tha within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bultimore, MD 21227 23a) (Type Print) 30. Name and address 9 805 HEN Benson Kell 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** SHIRLEY TUSING 2:30 A 80 10 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FOREST HILL HARFORD MARINER HEALTH OF FOREST HILL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 M 20 F Yrs. 213-58-2663 54 Sept. 9,1949 West Virginia Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or itams 23s or 28s-f show the Medical Examinar must be nutitied at 1 ☐ Yes 2 No Maryland Harford Forest Hill Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 109 Forest Valley Drive 21050 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 絮 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify ξ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other than 11 Years Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any singly or other traumatic event 90Rg. 17. Father's Name (First, Middle, Last) Be Marjorie Yoak Manuel Alvarez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laurentum Pkwy. Abingdon, Maryland 21009 Mrs. Tammy Killian-Sears 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Jesus Cem. 8/13/2004 * 4 □Donation 5 □ Other (Specify) Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility uda-Ruck Funeral Home of Dundalk, Inc. 7992 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate ot enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) d glu **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 90 1 Yes 2 No 3 Probably 4 Unknown Be Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 s has certificate 1 ☐ Yes ~2 ☐ No Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Alter or Attending 5 Pending 1 Natural 1 Tes 2 No after death. 2 Accident the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral C To the Hospital completely filled 29a. Certifier Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Duguest 10, 2004 032255 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 615 W. MacPHAIL ROAD, BEL AIR, MD 21014 DAVID S. DUNN 32. Registrar's Signature 31. Date filed (Month, Day, Year) sporks State AUG 1 3 2004 Registrar

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/Medic		4a. Facility Name (If not institution,	give street and number	or)	4b. City, Town,	or Location	of Death	AUGUS'		1.200	
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Funeral Director		5. Social Security Number 212-94-6751 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 🖫 F	Age (In yrs. last birthday 32 Yrs.	Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da 9 / 5 / 7	th ly, Year) 1	Co	nplace (State or Forei untry) YLAND
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Month AM VALLENAN /Medical 2 2004 TZUBUFT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospice Center Randallstown Baltimore 8. Date of Birth
June 10, 1926 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Mary Tand **Funeral** 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 1 □ F 78 Min. 220-18-1893 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or Items 23a or 28a-f show other treumatic event, the Madical Examiner mast be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 115 Conewood Ave. U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 ☐Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygiene Important: If item 27 ie marked other than "r. any injury or other treumstic avant Elementary/Secondary (0-12) College (1-4or 5+) Contract Dept. Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oscar Dennis Pearl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelby Carter - daughter 61 Highfalcon Rd. Owings Mills, Md. 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens Aug. 16,2004 Finksburg, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. elito 12 X 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11605 Reisterstown Rd. Owings Mills, Md. 21117 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician BILATERAL LULMUNARY EMBOLLSM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MADHE I'UL MONARY OBSTRUCTIVE Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68769 The law requires that the death certificate be Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 1 Yes 2 Y No To the Hospital or Attanding Physician: "within 24 hours after death.

To the Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA After thi funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation s after de. Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicet Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mella m.o 041410 2004. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 JOGIMOER P MEHTAMO 31. Date filed (Month, Day, Year) RAMONICS TOWN. CENTER

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

AUG 1 3 200

			1 - For State Registrar	State of N	Maryland		artmen rtificate					giene Reg. No.	104	25606
П	Physici	an									2. Date of Dea Month	ith Day	Year	3. Time of Death
	/Media		Beate Ruh			Oppen					August	10	2004	10:16 a ^M
	Examir	ner	4a. Facility Name (If not institution,		or)				Location of	of Death			inty of Death	
	Funeral		19 Wagner Stree 5. Social Security Number		Age (In yrs. la.	st birthdav)	Ann If Under	apo1	1S If Under	24 Hrs.	8 Date of Birt		nne Ar	
	Funeral Director		031-32-9226	1□M 2/CXF	86	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day July 2,	1918	Swi	place (State or Foreign ntry) tzerland
	D >		Usual Residence of Decedent 10a. State 10b. County		140-00						J			
	shov	5		1 1		Town or Lo							1	0d. Inside City Limits
	the N	Director	MD Anne A	runde1	Ann	apoli	10f. Zip	Code				10- 011		1XXYes 2 □ No
	be filed within 72 hours after death with the Marylan ital Hygiana. Ided other than "natural", or flems 23a or 28a-f show of other than "natural", or flems 23a or 28a-f show event. It a Madical Examinar must be notified at		19 Wagner Stre	at.			101. Zip	214	.01				of What Cour	
	death ms 2	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.	Was Deced			gin? (Sp	United Kin			
9	after or Ite	F.	1 Never Married 2 Marrie	Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give	MNo		lf Yes, spec 1 □ Yes 2		n, Mexicar Specify:		Rican, etc.)	1	Black, White,	
003	nours ural',	d by	3 Widowed 4 Divorced	Year or Dates	:							Spe	city: W	nite ———————
15-	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examinar must be routified at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa k done d	ation Juring mos	t of work	ing	16b. Kind o	f Business/In-	dustry
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			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cause	ed the death.	Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory arr	est,	M) 2140	Approximate
B	Physician		Immediate Cause (Final disease or condition	0 1	nonai	0	in to	1,10						Interval Between Onset and Death
	/Medical		resulting in death)		is a conseque		MIC	ins.					-	O
4	Examiner		Sequentially list conditions,	b. Deep	vei	n th	wow	505	515					3days
	ed seit	Examine	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of a	в а попъсоше	nna of):								J
	ai-trar	xan	that initiated events resulting in death) Last	c. Due to (or a	s a conseque	nce of):								
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9	tificate ng phys as the	Physician/Medical		u.										
Вох	death certifica e attending pt id for use as ti	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of delive		,
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tal	ician: Th certificate rector, pag	O	25. Was case referred to medical						26 Place	of Death	1 Yes 2	No	1 🗆 Yes	2□ No
\	Q 5.	To B	examiner? 1	Hospital: 1 ☐ Inpat	tient 2 EF	VOutpatien	t_3 DO/	Othe	_		ne Reside		Other (Specify)
Division of Vital Records	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury 21 lay Year)	Bb. Time of Injury	28	c. Injury Work	at		28d. Describe ho			
isio	Attending in death. ector: After by the funer	cat	2 Accident investigat 3 Suicide 6 Could not	he		,	М		es 2 🗆 N					
<u>></u>	- 6	Certification:	4 Homicide determine	286. Place of Ir	etc. (Specify)	e, tarm, str	eet, factory,	office			28f. Location (St City or Town	reet and Nu 1, State)	mber or Rurai	Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physician: To the bes	t of my knowle	edge, death	occurred a	t the time	a, date and	d place a	and due to the ca	use(s) and	manner as et-	ated.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the care (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the care of the care										ate and plac	e, and due to	the cause(s)		
	To th Withi To th comp	M	29b. Signature and title of certifier				29c.	License	number		2	9d. Date sig	ned (Month, L	Day, Year)
•			Barbara L	Bean	MD		D	39	497	7	1	tuani	t 11	200H.
	2		30. Name and address of person wh	o completed cause of	death (Item 2	За) (Туре,	Print)		1			U	1	0
			31. Date filed (Month, Day, Year)	002 M-	HOW (a	1 Pa	MIN	iay	,471	naj	DOUS, 1	Jary	land	21401
	Sta Registr		AUG 1 3 2004	A STATE OF THE PARTY OF THE PAR	sar a signatur	" play	g were			,	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Meducal Cent 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗹 F Months Hours Min. 219-26-7464 Director Usual Residence of Deced filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location orient: If item 27 is marked other then "naturel", or items 23a or 28e-1 ehow injury or other traumatic event, in a Medical Examinar must be notified at 10d. Inside City Limits 1 Tes 2 No **Funeral Director** Baltimone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 uc 84. - Apr 10 USA 21205 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: Be Completed by Specify: 3/act 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ent: If item 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Laborer Bankma 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Blaine Young Waddel George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pennsylvania Ave Apt. 14, Balt. MO 2120) 903 Ivsula Hill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: If eny injury or 8-16-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funen 23a. Part1. Enter the dise to for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner ieta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 2 → No 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? (es 2 No this certificate 1 Yes or Attending Physicien: 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA To the Funerel Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Display the time of the cause(s) and manner as stated.

Display the time of the 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D august 10, 2001 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,4940 Eastern

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Baltumore MD

RARY

5 MODOIN

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) +4200 2.45PM **Physician** MGUST Mary Agatha Widdows /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a BALTIMORE STAGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jun 22, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Days **Funeral** Months 1 □ M 2 □ F 1907 Maryland 97 212-09-0203 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location the Maryland 10a State 10b. County 28a-f show the Medical Exeminar must be notified at 1 ☐ Yes 2 ☐ No Catonsville Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or USA 21228 707 Maiden Choice Lane, Apt. 9G08 death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: filed within 72 hours after 1 Never Married 2 Married 0 1 Yes 2√ No Specify: Specify: Baltimore, Maryland 21215-0036 White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygient Important: If item 27 Is marked other tha any injury or other treumatic event, the 1 once. Bookkeeper Oil Refinery 12 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minerva Henderson James Nolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10625 Trotter Drive, Hagerstown, Maryland 21742 Cheryl C. Schweinhart / niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 8/9/2004 4 ☐Donation 5 ☐ Other (Specify) New Cathedral Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. reland 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Clostridium Difficile 9072 Priysician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whiknown renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes certificate 25. Was case referred to medical 26. Place of Death | Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours efter within 24 hours e To the Funerel D 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier b16632 BABATUNDE OLUMIDE. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEALTHCARE BALTIMORE SAINT AGNES 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 3 2004

			For	State of Marylar	nd / Depa	artment of H	lealth and M		_	oie.
			- State Registrar		Ce	rtificate of	Death		Reg. No.	25609
	Physici /Medio		1. Decedent's Name (First, Middle, Las John We	1 1					ST 13,3	3. Time of Death 2004 0432 A M
	Examin	er	4a. Facility Name (If not institution, give Holiday Inn 18	ostreet and number) #10 00 Belmont	5 Ave	Woodla		J	4c. County of Balti	more
	Funeral Director			7. Age (<i>In yrs.</i>	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Mar. 6	th ly, Year) , 1926	9. Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County New York Bronx		ty, Town or Lo Bronx					10d. Inside City Limits 1√2 Yes 2 □ No
	h with the 3a or 28e st be not	Funeral Director	10e. Street and Number 320 East 156th	Street #4E		10f. Zip Code 1 0	451		10g. Citizen of W	hat Country?
5-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "ratural", or liems 23a or 28a-f show maric avent, the Marilaal Examiner must be notilled at	Ď	11. Marital Status 1 Never Married	12. Was Decedent Ever in U Armed Forces? 1, Yes 2 No If Yes, Give Year or Dates WW 2		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	dispanic Origin? (Si an, Mexican, Puent Specify:	pecify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, k, White, etc. Black
<u>2</u>	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of wor	king	16b. Kind of Bus	
12121	filed within Hygiene. other then	Completed	Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		nitor			New Yo Author	
anc	should be fi ind Mental H is marked of umatic aver	To Be	Godwyn De Lilly	e, Sr.			Loret		, Maideir Garriaine	*/
Σ	and 2 shou ealth and M n 27 is mer		19a. Informant's Name/Relationship (7 Virginia Weathe	Type, Print)	19b. Maili 329	ing Address (Street East 15	and Number or Ru 6th Str	A Poute Number	er, City or Town, S	State, Zip Code) W York10451
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic 2008.		20a. Method of Disposition 1 Burial 2 Cremation 3 Other (Specify		comptany cra	osition (Name of matory or other place unt Ceme	etery 8,	Date /14/04!		City or Town, State re, Maryland
Baltii	permit. Pepartm Departm Importar any injur		21. Signature of Funeral Service II in		5	2. Name and Addre	stersto	atman-H vn Rd H	Harris Baltimo	Funeral Home re, Md21215
760,	Physician / Medical Examiner	icai Examiner	23a. Part1. Enter the disease, or company, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	quence of):	ter the mode of dyir	1		,	Approximate Interval Between Onset and Death I O year S
P.O. Box 68	Attending Physician: The law requires that the death certificate r death. r death. ector: After this certificate has been signed by the attending physy the tuneral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnanc	у		23d. Date Mon	o of delivery th Day Year
	uires that the signed by detaction	b	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	underlying cause giv	ven in Part I.		obacco use contri Yes 2 No	bute to the cause of death?
Division of Vital Records,	The law requir ate has been si page 2 should I	Completed						24a. Was autor perfo	osy promed? de	Vere autopsy findings available for to completion of cause of path? Yes 2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hannibal.			26. Place of Dea	th (Check only o		7. 1. 1. 7
of \	Physi this c	. To	1 Yes 2 No 27. Manner of Death		ER/Outpatie		4 Nursing n	ome 5 Resident	dence 6, Othe	r (Specify)Helliday Inv)
<u>o</u>	nding f ath. r: After ie funer	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	of 28c. Injui Wor M 1	rk? Yes 2∐No			
Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At the building, etc. (Special		reet, factory, office		28f. Location (. City or Tou		r or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Director completely filled in I	Medical (ysician: To the best of my kn niner: On the basis of examin and manner stated.						
L	To the To the comp	Ž	29b. Signature and title of certifier	Leed B		29c. Licens	6667		A	(Month, Day, Year)
	/	/	30. Name and address of person who	completed cause of death (Ite	23a) (Type	Delen				13,2004
	5		Philip Milit	ello MD 6	Tun	uple H:	II CT.L	uthor w	MeMa	my land 21093
	Sta	ate	31. Date filed (Morkh, Day, Year)	32. Registrar's Sign	TOTAL	KI				•

			State of Maryland / Department of Health and N 1- State Amend Item#20b, per FH, G834, 8/13/04.00. Certificate of Death	Mental Hygie	ene . 12004 25	610
	Physici	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Ti	me of Death
	- /Medi		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	,301. M
			9306 Hallsboro Cir. Apt. 101 PARKVILLE		BALTIMORE	S
	Funeral Director		5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birthday) H Under 1 Year H Under 24 Hrs.	8. Date of Birth (Month, Day,)	9. Birthplace (S Country) 3(a) MARYLI	tate or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		J. Julia jul	ide City Limits
	a-f sho	tor	MD BALTIMORE PARKVILLE			Yes 2/2/No
	with the a or 28a	Funeral Director	10e. Street and Number 9306 Hallsboro Cir. Apt. 101 21234.	100	. Citizen of What Country?	
	death ms 23;	eral		pecify Yes or No-	14. Race - American India	an.
36	within 72 hours after death with the Maryland ene. Than "natural", or llams 23e or 28e-f show na Mazical Eveniner must be notitled at	by Fur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 Yes 2 No If Yes, Give 1 Yes 2 No If Yes 2 No If Yes 7 Pates:	Rican, etc.)	Black, White, etc. Specify: White	
5-0036	72 hours aft "natural", or		15. Decedent's Education 16a. Decedent's Usual Occupation	. 16	ib. Kind of Business/Industry	•
121	within /	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	ang	Conta His	
3	tiled y	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle, Ma	(rab Haus iden Sumame)	<u>e. </u>
Maryland	2 should be tiled within and Mental Hygiene. Is marked other than aumatic avent, the M	ToB	Carl J. Walker DR Margo) vall	Larger Larger
Mar	is is		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N ber of Run 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N ber of Run 19b. Mailing Addres	ral Route Number, C	11 11	21234 MS)
ore,			201 71 171 171	204	c. Location - City or Town, Sta	te
	permit. Pages Department of I Important: If it, any injury or o		'4 Donation 5 Other (Specify) Mark Mark 18		ALTIMORE 1	ND
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Licental 22. Name and Address of Facility Primary Service Licental 23. Signature of Funeral Service Licental 24. Name and Address of Facility Primary Service Licental 25. Name and Address of Facility Primary Service Licental 26. Name and Address of Facility Primary Service Licental 27. Name and Address of Facility Primary Service Licental 28. Name and Address of Facility Primary Service Licental 29. Name and Address of Facility Primary Service Licental 20. Name and	LTIMORE	MARFORD R	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest		
f - F	nysician /Medical		Immediate Cause (Finel disease or condition resulting in death)			and Death
	Examiner		Due to (or as a son sequence of);			
7	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury			
P	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last			
8768	cate be executed physician and the burial-transit	dical	d			
Box 6	attending p for use as	/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
). B	the death certifi y the attending I tched for use as	hysician/Me	in the past 12 months? 1 Yes 2 No		Month Day	Year
P.0	inat the de led by the a detached i	Ω.	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause	of death?
Records,	ine iaw requires mat ite has been signed b age 2 should be deta	ed by		1 Yes	2 No 3 Probably 4	4 ⊡Unknown
Seco.	has be	ompleted		24a. Was an autopsy	24b. Were autopsy findi prior to completion	ngs available of cause of
		e Cor	25. Was case referred to medical 26 Place of Death	perform	death? No 1 Yes 2 No	
of Vi	S S S	To B	examiner?	h <i>(Check only one)</i> me 5 % Residenc	e 6 Other (Specify)	
	After After funer	tlon:	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
	after death. Diractor: After in by the fune	Certification	3 Supide 6 Could not be	28f. Location (Stree City or Town, S	t and Number or Rural Route I	Number,
٦	tely filled in by		- Sulfalling, Clo. (Opposity)			
-	within 24 hours after of Mithin 24 hours after of To the Funaral Dirac completely filled in by	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation.	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cau	se(s)
	within 2 To the complet	Me	29b. Signature and title of certifier 29c. Signature and title of certifier	29d	Date signed (Month, Day, Yea	ır)
•	/-		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11109.	
	4		DR. Rahnama, 9512 Harford Rd. Baltimore.	MD 21	234	
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rannance, 9512 Harford Rd, Bruttmare, 31. Date filed (Month, Day, Year) 32. Registrer's Signature AUG 13 2004			

			1 - For State Registrar	State of M	arylan	-	artmer rtificat				R	leg. N o. () ()		256	
	Physici /Medio		1. Decedent's Name (First, Middle, Last Ambrose Charles								2. Date of Dea Month AUGUST	Day	Year OOY	3. Time of	Death
	Examir		4a. Fecility Name (If not institution, give				4b. City,	Town, or			9	4c. County	of Death		
			Union Memorial H 5. Social Security Number 6. Se		a (la)		If I Indo	r 1 Year	Balt				N/		
	Funeral Director			A	9 (In yrs. 1	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Jan. 23	, 1929	9. Birthi Cou M	place (State ontry) arylan	or Foreign .d
	yland now		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside Ci	ity Limits
	72 hours after death with the Maryland naturel', or Items 23e or 28e-f show disal Examinar must be notified at	ctor	Maryland N/A				Ва	ultim	ore					1X Yes	2 🗆 No
	or 26	Dire	10e. Street and Number				10f. Zip				1	l0g. Citizen of V		•	
	s 23e	sral	608 East 34th Str	2et 12. Was Decedent	Consis III	C 140		212			7 14 11		S. A.		
'	fter de ritem inerr	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		5. 13.	was Dece	cify Cubar	n, Mexicar	gin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	Blace	k, White,	can Indian, etc.	
036	rel', o	þ	3 X Widowed 4 ☐ Divorced	1 X Yes 2 □ I If Yes, Give Year or Dates 1	946-1	948	1 🗌 Yes	2 X No	Specify:			Specify	:	White	
21215-0036		Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of wo	rk done di	urina mosi	t of worki	ng	16b. Kind of Bu	siness/In	dustry	
121	filed within Hygiene. Ither then "	dmo	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5	5+)	life.	DO NOT u Ma	se retired) Chan				A	tama	biles	
d 2	Hygi other ent,	Be Co	17. Father's Name (First, Middle, Last)				Me			er's Name	(First, Middle,	Maiden Sumam		unes_	
/lan		To B	William Howard We	ber					Est	tella	M. Giu	erke			
Maryland	d 2 should th and Men 7 Is marke treumatic		19a. Informant's Name/Relationship (T)	rpe, Print)								, City or Town,			
	s 1 and f Health item 27 other tr	1 3	Bruce Weber (Son) 20a. Method of Disposition		20h BI	24 1	Rader	Cow	it, B			aryland			
nor	60° ≥ 5		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State		ace of Dispo						20c. Location -			,
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify)21. Signature of uneral Service Licens	a p:	Gar	dens (_					Baltimo. Funeral			na
Ã	pemit. Departn Importe any nju		1 Jain D. J.	uis.								e, Mary		-	
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each li a	10. }	te R	er the mod		such as	cardiac o	r respiratory arr	est,		Approximate Interval Bets Onset and D	ween Death
	Examiner	er	If any loading to immodiate	b. Due to for as	Pr	eum	onio						_	1200	45
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury	Due to (or as	a consequ	Se sence of):	ptic	Sh	ock	,				20 de	ays_
68760,	icate be e physiciar s the buris	edical E		d	D	ilate	d Co	irdi	om	yopa	ithy			8 ye	ars
P.O. Box (law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pi Other (sp					23d. Date Mor		,	/ear
	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death b	ut not resu	Iting in the u	nderlying d	ause giver	n in Part I.		23e. Did tot	pacco use contres 2 No		ne cause of do	
Records,	0 5 0	Completed									24a. Was a autops perform	med? p	rior to cor	psy findings ampletion of ca	
Vital	sicien: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	Check anl on			200-110	
	99 (9)	은	1 ☐ Yes 2 ☐ No	lospital:		ER/Outpatien		Other	4 🗆 Nu			ence 6 Othe		y)	
no	ding h. Afte fune	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	M	8c. Injury : Work?	at ? es 2 □ h		8d. Describe ho	w injury occurre	∍d		
Division of	or Atten ifter deal Director in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	ury - At hor c. (Specify	me, farm, str					8f. Location (St. City or Town	reet and Numbe n, State)	or Or Rura	l Route Numb	ber,
_	Hospite 4 hours Funerel tely fillec	ledical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis of and manner sta	i examınatı	vledge, death ion and/or inv	occurred vestigation	at the time , in my opi	e, date and nion, deat	d place, a	nd due to the ca	ause(s) and mar ate and place, a	ner as st	tated. the cause(s))
	To the within 2 To the complex	Me	, 29b. Signature and title of certifier	^	-			. License				9d. Date signed			
	97		▶ ly Swami	hasad.	MI)	A	T20	38	946	B12	AUgust	- 10	200	DO
1	0//		30. Name and address of person who co	ompleted cause of d	eath (Item	23а) (Туре,	Print)	1)		D	August	, , ,		1
7	U		SWami Gade	30 Pagists	ast	Univ	ersit	y to	arki	way	Dalf	imore	<u>M</u>	D 212	18
	Sta Registr		31. Date filed (Month, Day, Year) AUG 13 2004	32_Registra	ar s ridl	1		ı		,					

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ORIGINAL

			ricasc	State of Manuage				•	-	ne.
			For State	State of Maryland		nent of H			200	1 00010
			Registrar 1. Decedent's Name (First, Middle, Las.	t)	Certin	cale of t		R. Date of Deal	eg. N6.	3. Time of Death
	Physici		CHESTER B. WI				/	WOOTH US	Day	Year 36/1 M
	/Medio Examir		4a. Facility Name (If not institution, give		4b.	. City, Town, or	Location of Death	rugus	4c. County o	f Death
			STELLA MARIS	@ MERCY		BALT	IMORE			N/A
	Funeral		5. Social Security Number 6. Se 220-18-3983	ZIM OFF	Mo	Under 1 Year Inths Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	ļ	Usual Residence of Decedent	78	115.			4/11/	26	MARYLAND
	yland		10a. State 10b. County	10c. City,	Town or Locatio	n				10d. Inside City Limits
	e Mari	ctor	MD N/A	ВА	LTIMOR	E				1 N Yes 2 No
6	ith th	Director	10e. Street and Number	7500	10	Of. Zip Code		1	0g. Citizen of Wi	nat Country?
nester	hours atter death with the Maryland tural, or Itams 23a or 28a-f show al Examinar must be notified at	eral	1344 BROENING	HIGHWAY 12. Was Decedent Ever in U.S	12 14/201		1224	4 VN-	USA	
to "	r Itam	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces?	If Yes	s, specify Cuba	ispanic Origin? (Spec n, Mexican, Puerto R	ican, etc.)	Black	- American Indian, , White, etc.
93	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW I	I 1 T	es 2 ⊠ No	Specify:		Specify:	WHITE
5-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Decedent's (Give kind	Usual Occupa	ation furing most of working)	7	16b. Kind of Bus	iness/Industry
22	filed within 72 Hygiene. Ither than "nat	dmi	Elementary/Secondary (0-12)	College (1-4or 5+)				-	D A I (11 T M	ODE GIEN
5k	be filed within ital Hygiene. Id other than event, the W		17. Father's Name (First, Middle, Last)	U	<u> </u>	REMAN	18. Mother's Name (ORE CITY
an Z		To Be	JOHN WISNIEW	SKI			Sophia	Rokic	ka	
a Co	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailing Ad	dress (Street a	and Number or Rural	Route Number,	City or Town, S.	tate, Zip Code)
(S)	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		MRS. JOHNNIE WI		1344 B	ROENIN	NG HWY. I			
ال ق	000		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State	netery, cremator	v`or other place	Da ME. 8/14/	Eu		ity or Town, State
Itin 6			4 □ Donation 5 □ Other (Specify,21. Signature of Funeral Servica Licens				1		UNDALK	
→ Ba	permit. Departn Imports any inju		1 Eyene.	Custon	A. I		KT ^{aci} FUNEF ALK AVE.			
			23a. Part1. Enter the disease, of comp shock, or heart failure. List only of	lications that caused the death.						Approximate
	Physician		Immediate Cause (Final disease or condition	THE GRASS OF GRASS MITE.	1.500		unce			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):		en co			
	LAGITITIE	_	Sequentially list conditions, if any, leading to immediate	b Due to (or as a conseque	200 000					
As -	nted Insit	Examiner	Cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	silce oi).					
0/1/2	e be executed /sician and e burial-transit	Exal	that initiated events resulting in death) Last	c Due to (or as a conseque	ence of);					
799	0 5 0	Ical		d						
Box 68	leath certificate b rattending physic I tor use as the b	Physician/Medl	IF FEMALE:							
Bo	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of	death 3 □Ecto	pic pregnancy			23d. Date Month	
P.O.	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5 ☐ Othe	er (specify)			in sing	, buy rear
ر. م.	that the poly of t	by Ph	Part II. Other significant conditions co	ntributing to death but not result	ting in the underly	ing cause give	n in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
rds	w requires been sign should be	ed b						112 Ye	s 2□No 3	☐ Probably 4 ☐ Unknown
000	law re as bee 2 sho	Completed						24a. Was an	24b. We	re autopsy findings available
Ä	The ate ha	Com						autopsy perform 1 Yes 2	red? dea	or to completion of cause of ath? Yes 2 \(\sum \) No
Vita	ysician: is certitic director,	Be	25. Was case referred to medical examiner?	Jamitali			26. Place of Death	Check on one		-
Jo	Phys r this ral dir	. To	1 Yes 2 No		R/Outpatient 3[28b. Time of	DOA Othe	4 Nursing Home		nce 6 cher w injury occurred	
O	ding th: : Afte	tlon	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	? 'es 2 □ No	J. Describe no	w injury occurred	
Division of Vital Records,	Attar actor by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fa	actory, office	28	Location (Str.	eet and Number	or Rural Route Number,
ā	spital or Attanding Phours after death. Incel Diractor: After the filled in by the funeral	Cert	- I TOTHISIOS	building, etc. (Specify)				City or Town,	, State)	
	To the Hospital or Attanding Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examione)	sician: To the best of my knowl ner: On the basis of examination	ledge, death occu on and/or investig	urred at the tim ation, in my op	e, date and place, and inion, death occurred	due to the ca at the time, da	use(s) and mann te and place, and	er as stated. d due to the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and manner stated.		29c. License				Month, Day, Year)
	~ s ~ ō		My has	~		0	40854		1	1
	,		30. Name and address of person who co		23a) (Type, Print)			0	14	2004
	6		Darie	Kiseberg mp	301	57 6	יהו פנ	12.	grant TI	21202
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	re	9.0				

		State of Maryl 1- Statemend Item#20b&c,per FH,G	and / Depa 334,8/1 ₂ 3	artment of He	ealth and <mark>I</mark> Death	Mental Hyg	giene Reg. N2 () (14	25613
		Decedent's Name (First, Middle, Last)				2. Date of Dea	ith		3. Time of Death
Physicia /Medic		Gertrude Veronica Walsh				August	7 th	Year 2004	09:40 AM
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	ocation of Death	1	4c. County	of Death	
		Upper Chesapeake Medical Cent	er	Bel Air			Har	ford	
Funeral Director		145-24-1826 ¹□м ²¬F 71	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth	Y#1933	Coun	ace (State or Foreign try) Jersey
and		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				1	Od. Inside City Limits
Maryl f ehc	tor	NJ Monmouth		squan					1∛∑Yes 2 □ No
the	Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of	What Coun	trv?
h with		45 Stockton Lake Boulevard		0873	6		United	Stat	es
ems ems	Funerai	11. Marital Status 12. Was Decedent Ever in Armed Forces?	u.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (S	ecify Yes or No-	14. Rac	e · Americ	
36 safter	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 🎗 ☒ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	orticali, etc.)	Specif	ok, White, e	ite
hours turel	d be	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a David	deade Usual Occurre					
15 in 72	Completed	(Specify only highest grade completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	ring most of wor	king	16b. Kind of B	usiness/inc	ustry
212 d with giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Ad	lministrat	or		feder	al go	vernment
nd file	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, i	Maiden Suman	ne)	
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f ehow eumatic event, the Medical Examiner must be nutified at	To	Frank A. Sowul			Gertrude	Jasiens	ski		
Mar und 2 shu alth and 127 la m or treum		19a. Informant's Name/Relationship (Type, Print) Keith P. Walsh/son		ng Address <i>(Street</i> ar Clizabeth					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "naturel", or any injury or other treumatic event, the Midcell Exami		1 □ Burial 2 □ Cremation 3 ⊠ Removal from State G	Place of Dispondence of Anne	nations or other place,	8/18/	Date (04)	20c. Location - Vall Tw	City or Tor	wn, State N,J.
Balt permit. Departitimport any inj once.		21. Signature of Funeral Service Licensee		Name and Address Chimunek 10 W. Mac					
		23a. Part1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.						4. 21	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition Acust 1	old oil	lad hon	an che	oie. S	hoke	7	Onset and Death
/Medical Examiner		resulting in death) Due to (or as a cons	quence of):	led hen	10 Fr Rey		7767	'	o occupy
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ted	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury	raquanda (H)						
58760, icate be executed physician and s the burial-transit	Exar	that initiated events c. resulting in death) Last C. Due to (or as a cons	sequence of):					-	
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68 tifficat tifficat ag phy as th	Φ.								
Box 63	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ F		Ectopic pregnancy				e of deliver	
Records, P.O. Box 6 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	1 Yes 2 No		Other (specify)			Мо	nth [Day Year
P.O hat the d by the letache		9 ☐ Unknown * 9☐ Unknown Part II. Other significant conditions contributing to death but not	rogulting in the		ia Danil	OZo Did tob		alle de la Maria	
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0 5 5 7	L ü	27. Manner of Death 28a. Date of Injury	28b. Time of		it	28d. Describe ho			
ision (trending F death. ctor: After / the funera	atlo	2 Accident investigation	injury		s 2□No				
or Atte	Certification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	eet, factory, office		28f. Location (Str. City or Town		er or Rural	Route Number,
Dital or urs after a small Dillied in					4				
DIVISIC To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my leading the physician of the basis of examiner: On the basis of examiner and manner stated.	knowledge, death ination and/or inv	occurred at the time restigation, in my opin	, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and ma ate and place, a	nner as sta and due to t	ted. he cause(s)
To I	ž	29b. Signature and title of certifier		29c. License			9d. Date signed	(Month, D	
10		m)		200	56607	A	eyust "	/ ",	2004
100		30. Name and address of person who completed cause of death (I	tem 23a) (Type, I	Print) TWOOD Ro	1. #11	06 BEL	ADR,	mo	21014.
Stat Registra		31. Date filed (Month, Day, Year) AUG 1 3 2004 32. Pegistrar's Sig	nature /	Soorkas					

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WALSH,

			1 For State			nd / Dep		Health and	Mental Hy	0001	05611
			Registrar 1. Decedent's Name (First, Mid	dlo I act)			runcate o	Dealli		Reg. No.	40014
н	Physic	ian							2. Date of De Month	Day Ye	
	/Medi	cal	Eleanor 4a. Facility Name (If not instituti	M. VVe	igman		T			- 10 - 2a	
4	Examir	ner						, or Location of Dea	th	4c. County of D	
			University of 5. Social Security Number	Maryland	7. Age (In yrs	Center	1301	ltimore			more City
	Funeral	н	-	6. Sex 1	1		Months Day		. (Month, Da	h y, Year) 9.	Birthplace (State or Foreign Country)
	Director		219-30-1167 Usual Residence of Decedent	/-	68	5 ''s.			01-	11-1936	Maryland
	land w		10a. State 10b. Coun	y	10c. C	ity, Town or L	ocation				10d. Inside City Limits
	f sho	ō	Manari and N	/ A		D 1.					1 XYes 2 □ No
	28a-	ect	Maryland N,	A		palt	imore			10 000	
	with b or	급					Tor. Zip Code	,		10g. Citizen of What	Country?
	eath	eral	1168 Nantio		ecedent Ever in I	16 40	Ittes Deceded	21230		U.S.A	
	lter d	Š	1 Never Married 2 Ma	Armed	Forces?	J.S. 13.	If Yes, specify Co	f Hispanic Origin? (uban, Mexican, Pue	nto Rican, etc.)	Black, W	merican Indi <i>a</i> n, /hite, etc.
36	rs af	by	3 ☐ Widowed 4 ☐ Divorce	If Yes	Give		1□ Yes 2■N	lo Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Marical Examilier is use the multified at	Completed by Funeral Director	15. Decede	ent's Education		16a Dece	dent's Usual Occ	cupation		16b. Kind of Busine	acc/nductor
15	in 7	plet		est grade complete		(Give	kind of work dor DO NOT use reti	ne during most of wo	orking	Too. Tand of Edaine	is a modelly
77	iene iene	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		Housewif			Home	
	Hygie other ent, II	O	17. Father's Name (First, Middle	, Last)					me (First, Middle,	Maiden Sumame)	
lan	ld be ental ked (To Be	Walter	Copperthi	te			1.5	dia	Fontz	
Maryland	2 should be f and Mental h Is marked of eumetic eve	-	19a. Informant's Name/Relation			19b. Maili	na Address (Stre			r, City or Town, State	e Zin Code)
M	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel; or Items 23a or 28a-1 show amportant: If item 27 is marked other then "neturel; or Items 23a or 28a-1 show amy injury or other treumetic event, Ite Marical Exemitier usi be redified at ODGS.		John J. Weigma	ın							yland 21230
e,	Health tem 27 other tr		20a. Method of Disposition		20b.		osition (Name of matory or other p		Date	20c. Location - City	
lo I	Pages nent of thant: If ite ant: If ite		1 Burial 2 Cremation	3 Removal from				Park 08-1	/O/.		
Baltimore,	permit. Pag Department Important: I eny injury c		* 4 □ Donation 5 □ Other (21. Signature of Fund Service		61		2. Name and Add		.4-04	Gren purn	ie,Maryland
Ba	permit. Departr imports eny inju		21. Signature of Full Control	1986	1.0.1	/ / M		olvniak E	uneral H	ome P.A.	
			222 Part Enter the disease	7 / Cell	MINO	2:	37 E. Pa	tapsco Av	enue, Ba	ome P.A. 1timore,	Maryland
			23a. Pard. Enter the disease, slock, or heart failure. Li	at only one cause or	each line.	itti. Do not em	ter the mode or d	ying, such as cardia	ic or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Priysician		Immediate Cause (Final dease or condition resulting in death)	_ a Cc	rdio pu	lmonan	7 Arrest				Oriset and Death
	/Medical Examiner		resulting in dealin)	Due t	o (or as a conse	quence of):	^ 1				
		L	Sequentially list conditions,	b. /V(,	yocard	ial In	tarctic	n n			Days
	pe ‡i	Examiner	Sequentially list conditions, any, sacrages in recials cause. Enter Underlying Cause (Disease or injury that initiated events	4	o (or as a conse	1	10. 10. 11.				Days Years
	and -tran	cam	that initiated events resulting in death) Last	0.	vonan		OIS	e			Tears
760,	te be executed ysician and se burial-transit	E E		Due (o (or as a conse	quence or):					
87	eath certificate be executed attending physician and for use as the burial-transit	dlcal		d							
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	20- 1/		.v					
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome of pregn birth 2 Pet	al death 3	Ectopic pregnar			23d. Date of a	delivery Day Year
<u>.</u>	the a	slc	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐Pre 9☐Unk	gnant at time of a	death 5	Other (specify)			World	Day real
P.0	uires that the death isgned by the atter Id be detached for u	Ph		tions contribution to	double but not an	audia a ia da			20. Didd		
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orc	w requir been si should	ted	Mesentenic is	nemia					1 L Y	es 2□No 3⊠	Probably 4 Unknown
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<u> </u>	The I	Con	Sepsis						perfor	med? death 2XNo 1 ☐ Y	?
ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medic examiner?	al				26. Place of De	ath (Check only or		
<u></u>	nysic nis ce dire	2	1 ☐ Yes 2 No	Hospital:	npatient 2	ER/Outpatier	nt 3 DOA	Other: 4 Nursing I	Home 5 Resid	ence 6 Other (S	pecify)
	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pend		e of Injury onth, Day Year)	28b. Time of Injury		ury at ork?	28d. Describe h	ow injury occurred	
Division	Attending r death. sctor: After by the funer	atle	2 Accident inves	tigation	,,,	,,		☐Yes 2☐No			
<u> </u>	I or Attendi after death. Director: A I in by the fu	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286. Pla	ce of Injury - At h		eet, factory, office	9	28f. Location (S City or Tow	treet and Number or	Rural Route Number,
Ö	s aft s aft el Di	Certification:		5011	dirig, atc. (Dpoci	'97			City of Town	ii, State)	
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To t	ne best of my kn	owledge, deatl	occurred at the	time, date and place	and due to the c	ause(s) and manner ate and place, and d	as stated.
	n 24 n 24 ne Fu	Medical	one)	and ma	basis of examini inner stated.	ation and/or in	vestigation, in my	opinion, death occi	urred at the time, o	ate and place, and d	ue to the cause(s)
	To the I	Z	29b. Signature and title of certif	er /			29c. Licer	nse number	2	9d. Date signed (Mo	nth, Day, Year)
)_	111) / NEI	11/2			AU	41764	35 0	8-10-2	0014
8	///		30. Name and odress of perso	n who completed ca	use of death (Ite	m 23a) (Type,	D : ()				- 0
3)		PATRICK LEE	MD 22	Sutho	reene	St Bo	Mother M	0 2120	(
	Sta	ate	31. Date filed (Month, Day, Yea	2 2004 32.	Registrar's Sign	ature 4	Ann.	1/1			
	Registr	ar	Aug 1	3 2004	N. C. A. C.	10	jagria	ach.			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3.-Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:04 Αм 2004 August 11 Constance Marie Ward /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 9906 East Berliner Place "Apt.E" Baltimore Middle River If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F 64 214 54 4530 Sept.16,1939 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, the Medical Evantural pages. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☑ No Middle River Maryland Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9906 East Berliner Place "Apt.E" 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Marned 1 Yes 2 No Specify. Specify: White ģ 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geneva Rosalie Peyton Howard Lee Creswell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9906 East Berliner Place "Apt.E" Balto., Md. 21220 Gary Lee Ward (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Gardens Of Faith 8/16/2004 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signaure of Funeral Service Licensee 1407 Old Fastern Avenue Essex, Md. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Chronic ischemic heart **Physician** /Medical Due to (or as a consequence of) Examiner Typertinowe morice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner Hospitel or Attending Physician: The law requires thet the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the ettending physician by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) Yes 2 XNo 9 Unknown 9 Unknown ۾ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þe abetes elletino 1 Yes 2 No 3 Probably 4 Unknown Completed Cerebroverilan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 ☐ Yes 2X No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1⊠Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification: To this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident after death Director: 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel E filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier J. Crossan 10007632 Honovan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 0 DONOVAN 2112 DUNDALK AVE I CRESSAN 32. Registrar's Signature 31. Date liled (Month, Day, Year) State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

			1 _ Stete	•	epartment of Health and I Dertificate of Death	Mental Hygier	0001	00010
	_		Registrar 1. Decedent's Name (First, Middle, Last)		John Mario di Datan	2. Date of Death	10 11 11	3. Time of Death
	Physici	_	Anthony	Whi	te .		Day Yeer 2004	1 09:59 AM
1	/Medic Examin		4e. Facility Name (If not institution, give street		4b. City, Town, or Location of Death		4c. County of Deet	
			The Johns Hook,	is Hosptiah	Baltimore C	ity	Na	
	Funeral Director		5. Social Security Number 6. Sex 11144	7. And (In yrs. last birth	Months Davs Hours Min.	8. Date of Birth (Month, Day, Ye. Septembel 26,	ar) Co	nplece (State or Foreign
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Maryli f sho	ō	MD N/a	Bal	timure			1 Pres 2 □ No
	1288	rec	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
	h with	ai D	8/8 N. Collington A	V E	21205		U-5.A.	
	ems er m	Funeral Director	A	Vas Decedent Ever in U.S. med Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Bfack, White	
36	filed within 72 hours after death with the Maryland Hygien. Hygien. the than natural, or items 23s or 28s-f show ent, the Medical Examiner must be notified at	by Fu		Yes 20 No Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 2	
8	hour	edt	15. Decedent's Educatio	n 16a. D	Pecedent's Usual Occupation	16b	. Kind of Business/l	ndustry
21215-0036	n na	Completed	(Specify only highest grade con	mpleted) (Give kind of work done during most of worlife. DO NOT use retired)	king		,
27	d with giene er tha	E O	/U	0	PORTER	/	In port	
밀	ould be filed with Mental Hygiene arked other that atic event, the h	Be (17. Father's Name (First, Middle, Last)	,		ne (First, Middle, Maid	len Sumame)	
<u> </u>	should Ind Men	ျှ	Foseph White		Elesi		4	
-	Cl = 0	s i	19a. Informant's Name/Relationship (Type, F	·	Mailing Address (Street and Number or Ru	Beltimus y		ip Code)
	1 and Health em 27	- 3	20a. Method of Disposition	20b. Place of D	Drud Hill AVE Disposition (Name of crematory or other place)	-	Location - City or	Town, Stete
nor	Pages nent of I ant: If ito ary or o		1 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)		J CEME FERT	17/101	Bostowell	w/D
	permit. Pag Department Importent: Importent: 0 any injury c	1	21. Signature of Funeral Service Licensee	1911 200)	22. Name any didress of Facility	EHS Funer	21 Home	70
ä	Departition Depart		Faturia Best		1129 N. CARSLINEST			
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ens that caused the death. Do no				Approximate Interval Between
	Pnysician	(l. 1)	Immediate Cause (Final disease or condition	Seine	رع			and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	LXUITIITEI	<u>_</u>	Sequentially list conditions, b.	Due to (or as a consequence of	AIDS			6 years
_	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to for as a consequence of	<i>j.</i>			
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	ntifical ng phy as th	Medi	IF FEMALE:					
Вох	leath certifica attending ph I for use as tl	an/I	23b. Was decedent pregnant	f yes, outcome of pregnancy	3 Ectopic pregnancy		23d. Date of deli- Month	very Day Year
0.	ne dea the at hed fo	Physiclan/Me	1 Ves 2 No	I□Pregnant at time of death 9□Unknown	5 Other (specify)		i i i i i i i i i i i i i i i i i i i	54)
<u>ď</u>	ac ac		Part II. Other significant conditions contribu	iting to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
ds,	uires tha signed id be det	d by	HIV deug	Resistance		1 ☐ Yes	2 No 3 □ Pro	bably 4 Unknown
Vital Record	w requir been s should	Completed	0			24a. Was an	24b. Were au	opsy findings available
Be	The lav	omp				autopsy performed	prior to c death?	ompletion of cause of 2□ No
		a)	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	10 100	20,710
>	N S D	To B	examiner? 1 Ves 2 No Hospi	tal: 1 ☐ Inpatient 2 ☐ ENOutp		lome 5 Residence	6 □Other (Spec	ify)
0 _	or Attending Physician: after death. Director: After this certification by the funeral director,		27. Manner of Death 28 1 DNatural 5 □ Pending	Ba. Date of Injury (Month, Day Yeer) 28b. Tir	ury Work?	28d. Describe how in	njury occurred	
<u>sio</u>	uttendil death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	D. Disco of labour Atheres for	M 1 Yes 2 No	OSA Location (Street	and Mumber of Co.	and Charles More has
Division of	in Dirt	it.	4 Homicide determined 28	Be. Place of Injury - At home, farn building, etc. (Specify)	n, street, ractory, office	28f. Location (Street City or Town, St		al Houte Number,
_	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in I	C	29a. Certifier 1 Certifying Physicie	n: To the best of my knowledge,	death occurred at the time, date and place	, and due to the cause	(s) and manner as	stated.
	ne Hoo	edical	(Check only 2 Medical Examiner:	On the basis of examination and/ and manner stated.	or investigation, in my opinion, death occu	rred at the time, date a	and place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	110	29c. License number		Date signed (Month	
			Karole Squart	~ MD	RES-000	A	igust 11	,2004
	2		30. Name and address of person who comple	eted cause of death (ftem 23a) (T	ype, Print) 000 N Wolfe St Bo	16	110 0	200
	0.		31. Date filed (Month, Day, Year)	32. Registrar's Signature	00 N Wolfe St B	UTIMORE	MW 21	287
	Sta Registi		31. Date filed (Month, Day, Year)	Sz. Registrar's Signature	1			

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

AUG 1 3 2004

31. Date filed (Month, Day, Year)

Darks

Registrar's Signature

			For State	State of Marylar				Mental Hy	/giene	0.01	
			Registrar 1. Decedent's Name (First, Middle, Last)		Certific	cate of De	eatn	2. Date of D	Reg. No.	1114	3. Time of Death
	Physici /Medi		Sam William	S				Ail Gi	Day	" "	· OI D
	Examir		4a. Facility Name (If not institution, give s Good Saman Fa	· Hospital	50	City, Town, or Lo	COVEL f Under 24 Hrs.	BiV4	K	County of Dea	one City
	Funeral Director		5. Social Security Number 6. Sey 3 18 4 18 454 11 Usual Residence of Decedent	7. Age (In yrs. 55	Moi		Hours Min.	8. Date of Bi (Month, D	rth ay Year)	/ °/\	triplabe (State or Foreign
Maryland	a-f show	tor	10a. State 10b. County	100 0	ity. Town or Location	OPE					10d. Inside City Limits 1
th with the	23a or 28a-f	Funeral Director	10e, Street and Number BON	ing/touse	Rd. 10	of. Zip Code	212		10g. Giti	zen of What C	guntry?
036 urs after dea	al', or itams :	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes	Decedent of Hisp , specify Cuban, es 2 No	anic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi Specify:	
ind 21215-0036 be filed within 72 hours after death with the Maryland	f Health and Menial Hygiene. itam 27 is marked othar than "natural", or itams 23a or 28a-f shov othar traumatic evant, the Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondan) (5,12)	cation e completed) Collaga (1:40r 5+)	16a. Decedent's (Give kind life. DOW	Usual Occupation of work done during the DT use retired	on ing most of work	king	165 Ki	nd/of Business	Wholestry ST
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	sician and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec							
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vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certific	by the attending p tached for use as t	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c	al death 3 □Ecto	pic pregnancy er (specify)			2	3d. Date of de Month	livery Day Year
ords, P	been signed t should be det	ed by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the underty	ring cause given i	in Part I.		tobacco u Yes 2[the cause of death?
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Division of	death. ctor: After this y the funeral di	ation; To	27. Manner of Death No Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ZER/Outpatient 3[28b. Time of Injury M	28c. Injury at Work?	4 □ Nursing Ho	ome 5 Resi 28d. Describe			cify)
Divis Ital or Atte	Dir	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fa	actory, office		28f. Location (City or To		Number or Ru	ural Route Number,
A Hospitai	24 hou	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	nician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death occu ation and/or investig	arred at the time, ation, in my opini	date and place, on, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
To tha	within To th compl	Me	29b. Signature and title of certifier			29c. License nu		6	29d. Date	e signed (Mont	h. Day, Year)
	1		> & ha	e or	> .	700	1823	0	Aire	1457	2,2006
	5		30. Name and address of person who co	mpleted cause of death (Iter		6,00	SAN	IARIT	AN	HOSHI	2,2014 TAL, MIDO123
	Sta Registr		31. Date filod (Month, Day, Year)	32. Registrar's Signa		Souli					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AUGUST 2004 **Physician** WEBSTER MAUDIE 7:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANGELS ALERT INC, III ASSISTED LIVING HOWARD ELKRIDGE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/12/1917 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 1□ M 2 F **Funeral** Days Hours Months NORTH CAROLINA 228-40-8121 87 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State irai', or itams 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☐ No MD HOWARD ELKRIDGE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21075 USA 6526 GREENMOUNT DRIVE Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forcesty 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: BLACK 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: β 3 Widowed 4 □ Divorced "naturai", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic evant, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. INDUSTRY CHAR LADY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental I MCLUGHLIN CALVIN GOTNS MARY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) outment of Health a ortant: If itam 27 to highly or other tre JESSIE WEBSTER / DAUGHTER 3433 PLUM TREE DRIVE, ELLICOTT CITY, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State MD NATL MEM PK CEM 8/13/2004 LAUREL, MARYLAND * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityHOWELL FUNERAL HOME 21207 Deparament 4600 LIBERTY HEIGHTS AVENUE, BALTIMORE, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. oximate val Between et and Death Immediate Cause (Final Our Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unique that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): nding physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significan conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 DHC Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 6 Other Souls Lack Other: 4 Nursing Home 5 Residence 2 1 🗌 Yes 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Death Certification: After 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To tha Funaral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

0 32. Registrar's Signature

29c. License number

29d. Date signed

				epartment of Health and Mental Hygiene Certificate of Death
	Physic		1. Decedent's Name <i>(First, Middle, Last)</i> Frank Willard Watson	2. Date of Death Month Day Year August 11, 2004 9:00 a. M
	/Medi Examir		4a. Fecility Name (If not institution, give street and number) 5903 Farmview Avenue	4b. City, Town, or Location of Death Raspeburg 4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 217 40 4362 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min (Month Day Year) Country
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of MD Baltimore Raspel	Tod. Words Only Entitle
	3e or 28a	I Director	10e. Street and Number 5903 Farmview Avenue	10f. Zip Code 10g. Citizen of What Country? 21206 USA
980	d within 72 hours after death with the Maryland Jiene. rithen "natural", or Items 23e or 28a-f show the Medical Examiner must be troutiled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes ↑□ Yes Specify: 14. Race - American Indian, Black, White, etc. Specify: White
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Maryland	ges 1 and 2 should be filed it of Health and Mental Hygir If item 27 Is marked other or other treumatic svent, I	To Be C	17. Father's Name (First, Middle, Last) David B. Watson	18. Mother's Name (First, Middle, Maiden Surname) Mary C. Barham
	1 and 2 sho Health and em 27 is m		Mary Elizabeth Watson WIFE 590	Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Farmview Avenue Raspebur, Maryland 21206
Baltimore,	Pa Fr		cemetery,	Date 20c. Location - City or Town, State crematory or other place) 08/14/2004 Raspeburg, Maryland
Ball	permit, Departr Importe any inju			^{22.} Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237
	Physician	1	23a. Part 1. Enter the disease of complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	t enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Crophage at Cancer One
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al Reco	icien: The law requ certificate has been ector, page 2 should	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
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	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de construction and one one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to the cause(s) and manner as stated, or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
•	Tot Totl Comp	Ž	29b. Signature and title of certifier Bahri	29c. License number 29d. Date signed (Month, Day, Year) 8/11/0 4
	11		30. Name and address of person who completed cause of death (Item 23a) (Type Beller Row) 81114 50 A	pe. Print) La pipen Cincle, Super Palt Md 21236
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrare Signature AUG 1 3 2004	4. Social .

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Signature Committee Comm	Man od 2 s lith an 27 is i			ypa, Fility	830	01 Nunley	Drive Ap	a <i>i Houte Numb</i> t C Bal	er, City or Town Limore.	n, State, Zip Marv	^{, Code)} ·land 21234
Signature Committee Comm	s 1 ar f Hea itam othe		20a. Method of Disposition		20b. Place of Disp	osition (Name of		man Va			
23s. Part. Enter the disease, or combined that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Institute Cause) and a continuous or death in the past (2 months) and of the conditions of the cause of th	Page Page nent o int: If	Ш			1	_		2/04	Balti	more.	Marvland
23s. Part. Enter the disease, or combined that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Institute Cause) and a continuous or death in the past (2 months) and of the conditions of the cause of th	rmit. epartm eporte poorte y inju		21. Signature of Funeral Service Licen	S88	2	22. Name and Addre	ess of Facility Mi	11er-Di			
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANA KUSIO, M.D. 111 Penn Street, Baltimore, Maryland 21	To t To t	Σ	29b. Signature and title of certifier								
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21 Date filed (Meeth Cour Voor) 4 22 Degisterede Children	4		A		eath (Item 23a) (Type,		enn Street	. Balti	imore. M	arvla	nd 21201
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			1 - For State Registrar	State of M	Marylan		artment rtificate			and M	lental Hy	/giene Reg. №. (25622)
	Physici	an	1. Decedent's Name (First, Middle, I	Last)							2. Date of D Month	eath Day	Year	3. Time of Death	ń
	/Medi		Ruth Margare						or .		Augus	7 09		4 4:171	M
	Examir	ıer	4a. Facility Name (If not institution, g		r)		4b. City, T					4c. C	ounty of Death		
			St. Agnes Host 5. Social Security Number 6		Ago (In use	last birthday)	If Under 1		imor If Under:		0.000				
	Funeral Director		213-01-7475	1□ M 2⊠F	93			Days	Hours	Min.	8. Date of Bi	ay, Year)	9. Birth	place (State or Fore intry)	ign
			Usual Residence of Decedent								July 1	.0,191	1 Mary	land	
	laryian show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				-			10d. Inside City Lim	its
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	vith th	Director	10e. Street and Number				10f. Zip C	ode				10g. Citize	n of What Cou	ntry?	
	9ath v	erai	6348 Frederick					2122					S.A.		
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Maryland 21215-0036	12 s h ar 7 is		19a. Informant's Name/Relationship										own, State, Zip		
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B	permit. Departr Importe any inju		DG.		128	Wi	tzke]	une	ral	Home	of Cat	onsvi	lle, In	nc.	_
			23a. Part1. Enter the disease, or co	mplications that cause	ed the death		or the mode	of dying,	SON A	ardiac o	Catons r respiratory a	rrest.	, Mary	Land 2122	8
	Physician		Immediate Cause (Final	y one cause on each	iine.									Interval Between	
	/Medical		disease or condition resulting in death)	a. DECO Due to (or a	s a consequ	uence of):	ED (_ =	NGE	511	UE HEI	412, t	AILLINE	- GMEN	145
	Examiner		Constant to the first one of the con-		,										
	ם ב	ner	Sequentially list conditions, it also be a cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consuqu	ience of):									
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
8760,	cate be executed bhysician and The burial-transit		resulting in obality cast	Due to (or a	s a consequ	ence of):									
87	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		d											
9 X	eath certific attending p	by Physician/Me	IF FEMALE:	23c. If yes, outcom	e of prechai	ncv								- VIII-	
Вох	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal	death 3 🗆	Ectopic preg Other (spec					23d	Date of delive Month	ry Day Year	
0	that the de ed by the a detached	ysi	1 ☐ Yes 2 █No 9 ☐ Unknown	9□Unknown	at time of de	30	Other (speci	iy)						,	
۳,	res that igned b be deta	y P	Part II. Other significant conditions	contributing to death	but not resu	lting in the un	derlying cau	se given	in Part I.		23e. Did t	obacco use	contribute to th	e cause of death?	
Vital Records,	quire in sig uld b	d be	CONONARY	ARTE	ny	01-5	EASE	_			10	Yes 2□N	o 3 🗆 Prob	ably 4 Spriknow	'n
000	law requiras been si 2 should	piet									24a. Was	an 2	4b. Were autor	osy findings available	
ž	The la	Completed										rmed?	prior to cor death?	npletion of cause of	
		BeC	25. Was case referred to medical						6. Place o	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	20000	
	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 No	Hospital:	ient 2 🗆 E	R/Outpatient	3□ DOA	Other:				000	Other (Specify	•)	
Division of	Attending Physicien: r death. sctor: After this certific. by the funeral director.		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Date	ury ay Ye <i>ar)</i>	28b. Time of Injury	28c.	Injury a Work?			8d. Describe h			,	
Si Si	tendi leath. Ior: A the fu	catl	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	00			М	1 🗌 Ye	s 2 □ N	0					
\leq	or At fter d jirect in by	Certification;	4 Homicide determined	28e. Place of in	ijury - At hor tc. (Specify)	me, farm, stre	et, factory, o	fice		2	8f. Location (5 City or Tox	Street and North	umber or Rura	Route Number,	
Ц	pitel urs a erel [SON CONTROL AND CONTROL OF THE PROPERTY OF THE												1
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner's	A GYAHIIIAN	rledge, death on and/or inve	occurred at t estigation, in	he time, my opin	date and ion, death	place, ai occurre	nd due to the o d at the time, o	cause(s) and date and pla	I manner as sta ce, and due to	ated. the cause(s)	
	To the within To the comple	Š	29b. Signature and title of dertifier	and mariner's)			cense n					gned (Month, L		
	r s r ó		1 7 50	Lilla		MUS	2	00	61-	16					
1	1	-	30. Name and address of person who	completed cause of	death (Item	23a) (Type P					- '	7446	(7)	4 2004	_
6	/		ST AGNES 1	32. Regist	ANE	B	ALTI	RLA	KE	MA	421/1	ANT	-)		
			31. Date filed (Month, Day, Year)	32 Regist	rar's Signati		-//			,- 9	- 7 6				
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ZENTZ, RUTH

			For State Registrer	of Maryland / De	epartme Certifica			ind M		iene 9. Ng? []	101	25623
	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	Emily 4a. Facility Name (If not institution, give street and r		Auglis		Location of	1 Dooth	08/06/	_	nty of Death	3;00 A M
7	Examin	er	Bradford Oaks Nursing		40. 01	Clint		Death			•	eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthe		er 1 Year	If Under 2		8. Date of Birth			place (State or Foreign intry)
Ш	Director		579-46-1763 1□M 光図和	97 Yr	s. Month	s Days	Hours	Min.	(Month, Day, 05/20/1	907		Latvia
	and and	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location							10d. Inside City Limits
	ours after death with the Marylan al', or Items 23e or 28e-f ehow Examiner mout be notified at	to	Maryland Prince George'	s Oxon	H-11							1 ☐ Yes 🗶 🌣 No
	h the	irec	10e. Street and Number	S OXOII		ip Code			10	0g. Citizen	of What Cou	intry?
	23a c	Funeral Director	29 Alexandria Drive			2074	4 5			USA		
	tams	nue	Armed		13. Was Dec If Yes, s	edent of Hi ecify Cuba	ispanic Orig in, Mexican,	in? (Spe Puerto l	cify Yes or No- Rican, etc.)		lace - Ameri lack, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, 4 ☐ Six Wildowed 4 ☐ Divorced Year or	: X2 K No Bive Dates:	1 ☐ Yes	2 XX No	Specify:			Spe	cify: V	Vhite
21215-0036	be filed within 72 hours after death with the Maryland tall Hyglene. dother than "natural", or itams 23a or 28a-f ehow event, the Medical Examinat must be notilised at	ted	15. Decedent's Education	16a. D	ecedent's U	sual Occupa	ation	,		16b. Kind of	Business/Ir	ndustry
218	C * (1)	Completed	(Specify only highest grade complete: Elementary/Secondary (0-12) College	(1-4or 5+)	Give kind of ife. DO NOT		during most ()	of workii	79			
121	filed w Hygien ther th		17. Father's Name (First, Middle, Last)		Homen	aker	40 Matha	d = 81= =	/Fina Adiddle A	4-14 0		Home
Maryland	should be filed within and Mental Hygiene. marked other than imatic event, Ire M) Be					18. Mother		(First, Middle, A KNOWN	maiden Sum	iame)	
ary.	2 should be and Mental Is marked of sumatic eve	ဥ	UNKNOWN 19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Addre	ss (Street a	and Number		l Route Number,	City or Tov	vn, State, Zi	p Code)
		10	June Auglis / Daughter-	20					on Hill,			20745
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2XXCremation 3 □ Removal fro	20b. Place of D	isposition (N crematory o	ame of other plac	(e)	8/07	/200/		n - City or T	
Ë	nit. Pag artment ortant: I injury o	٠,	* 4 ☐ Donation 5 ☐ Other (Specify)	Kalas C		•	l l		L	dgewa	ter, n	naryland
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ligenses Willin Julia	nn	22. Name 6160	and Addres Oxon	ss of Geollity Hill	rge Road	P. Kala Oxon H	s Fune	eral H Maryla	Nome P.A.
п			23a. Part1. Enter the disease, Complications that shock, or heart failure. List only one cause or	caused the death. Do not each line.	t enter the m	ode of dying	_					Approximate Interval Between Onset and Death
	Fnysician /Medical	ľ i	Immediate Cause (Final disease or condition resulting in death)	THEROSCL		10	CA	RD	10VASC	ULAH		Onder and Double
10	Examiner		Due	o (or as a consequence of)	1					DIST	1st	
	100	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S (or as a consequence of)								
	ocuted and transi	Examiner	that initiated events									
60,	ate be executed hysician and the burial-transit		Due t	o (or as a consequence of)	*							
68760,	physics the l	edical	d.								-	
ox 6	leath certific attending p	Physician/Me		utcome of pregnancy	205					23d. (Date of deliv	ery
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P.0	that the dended by the detached		Part II. Other significant conditions contributing to		a underwing	Cauco and	on in Part I		23a Did toh	2000 1150 00	antribute to t	the cause of death?
of Vital Records,	The law requires that the death certificate be executed ite has been signed by the attending physician and age 2 should be detached for use as the burial-transit	ted by	PERIPERAL VAS	CULAR	DISE	ASE				s 2 No		
ecc	taw re tas be	Completed							24a. Was ar	y	prior to co	opsy findings available ompletion of cause of
E H									perform 1 Tes 2	ned? XXNo	death?	2 No
N X		Be	25. Was case referred to medical examiner? Hospital:	71		Othe			(Check only one			
	g Phys er this eral di	n: To	27. Manner of Death 28a. Dat	Inpatient 2 ER/Outp e of Injury 28b. Tin onth, Day Year) Inju	ne of	28c. Injury Work	XXXX		ne 5 Reside 28d. Describe ho			fy)
ion	Attending For death. ector: After by the funer.	atio	1XXNatural 5 ☐ Pending (Mic 2 ☐ Accident investigation	nth, Day Year) Inju	Iry M		<br Yes 2□N	10				
Division		Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm	, street, fact	ory, office		2	28f. Location (Str. City or Town		mber or Run	al Route Number,
Ω	spital or burs afte eral Dir filled in		CO. Cartillar III Cartital Division II									
	To the Hospital within 24 hours a To the Funeral C completely filled in	ledical		ne best of my knowledge, or basis of examination and/or nner stated.				i place, a h occurre	and due to the ca ad at the time, da	use(s) and ite and plac	manner as s e, and due t	stated. o the cause(s)
	To To Control	M	29b. Signature and title of certifier	1481 CLAN	$\Big $	9c. License Do	o number	7	§ 2	_	ned (Month,	Day, Year), 6th, 2004
	H		30. Name and address of page was sometimes of 170 LIVINGS TON	188 8 dea M Drem 23a) (T)	SUIT	E	101	,				N MD.
	Sta Registr			Registrar's Signature	lon	Ho!		/ - <u>-</u>				
			HOUT O FOOT		11							

			1000	1 - For State Registrar		Department of Healt Certificate of Dea	h and Mental H		4 25624
	>	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give	Frederick E.	Brown 4b. City, Town, or Locati	2. Date of Date of Augus	Day Va	
		1020	iei	Stella Maris H 5. Social Security Number 6. Se	ospice	Towso	n	Balti	more
		Funeral Director			2 5 6	Yrs. Months Days Hou	rs Min. (Month, L	Day, Year) M.	Birthplace (State or Foreign Country aryland
		e Marylan Be-f show lifts a st	Director	MD Baltim		Essex			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
		3a or 28	al Dire	10e. Street and Number 401 Margaret	Ave	10f. Zip Code 21221		10g. Citizen of What	Country?
р.ш.	036	within 72 hours after death with the Maryland ene. Than "natural", or liems 23a or 28e-f show Ita Maulcal Exemirer manal be notilied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1)∑Yes 2 □ No if Yes, Give Year or Dates:	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi		o- 14. Race - A	merican Indian, /hite, etc. nite
10:25	21215-0036	77 75 1	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	de completed)	a. Decedent's Usual Occupation (Give kind of work done during in life. DO NOT use retired) Laborer	nost of working	16b. Kind of Busine CityDept Public V	c, of
		ould be filed of Mental Hygistarked other arked other attic event. It	Be	17. Father's Name (First, Middle, Last) Earl Brown		Ì	other's Name (First, Middle		
2004		S D E E	2	19a. Informant's Name/Relationship (T	ype, Print) 19	Bb. Mailing Address (Street and Nur	rauline Mi		a, Zip Code)
5	≥	1 and 2 Health a em 27 Is		Donald Brown /	brother	401 Margaret	Ave. Balt	imore MD	2122
	TO T	m O		20a. Method of Disposition 1 □ Purial 2 □ Cremation 3 □ Purial 2 □ Other (Specify)	Removal from State cernet	of Disposition (Name of ery, crematory or other place) YHillCemetery	Date 8/20/04	20c. Location - City Baltimor	
AUGUST	Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licens		22. Name and Address of Fa	atte.	yFuneralH	HomeofEssex
	760,	The private transit the burial-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List erry of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and any leaving to influentiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. END STAGE I.IV Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ER DISEASE of):	as cardiac or respiratory a	rrest.	Approximate Interval Between Onset and Death
	O. Box 68	the death certificat y the attending phy iched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	h 3 Ectopic pregnancy 5 Other (specify)	70	23d. Date of o	lelivery Day Year
	rds, P	wrequires that the death been signed by the atte should be detached for	ed by Pt	Part II. Other significant conditions col	ntributing to death but not resulting	in the underlying cause given in Pai	_	obacco use contribute	to the cause of death?
		2 2 2	Completed				24a. Was auto perfo 1 Yes	psy prior to primed? death'	
RIC	Vital	rnysician: this certific ral director,	o Be	25. Was case referred to medical examiner?	lospital:	Oth	ice of Death (Check only o	one)	
FREDERICK		After this	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐ ER/O 28a. Date of Injury (Month, Day Year) 28b.	Time of Injury M 1 Tyes 2 [dence 6 X Other (Sp how injury occurred	ecify) HOSPICE
	2	or An after d Direct in by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)			Street and Number or i wn, State)	Rural Route Number,
		ine nospitel hin 24 hours a the Funeral I mpletely filled	edical (29a. Certifier (Check only one) 1X Certifying Physical Examination (Check only one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	ie, death occurred at the time, date ind/or investigation, in my opinion, d	and place, and due to the eath occurred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
		within To the comp	W	29b. Signature and title of certifier	17	29c. License numbe		29d. Date signed (Mor	nth, Day, Year)
				30. Name and address of person who co DR. TARIO MAHMOOD			NTIM AP 010	02	
	-3	Sta Registr:		31. Date filed (Month, Day, Year) AUG 1 6 2004	32. Registrar's Signature	Sports	NIUM, MD 210	7.1	

FREDERICK BROWN

	1	For Unpend Item	250,27,200	Ce	rtificate of	Death			4 25625
Physici		1. Decedent's Name (First, Middle, Last)	Sandra E	. Bas	9		2. Date of De Month		ar 3. Time of Death
/Medic	al -				4b. City, Town, o	r I continue of Dr	AUGUST	13, 2004 4c. County of	
Examir	ier	4a. Facility Name (If not institution, give st. 415 DELEWARE AVENUE			BALTIMO		atri		LIMORE
Funeral	-	5. Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 24 h	Irs. 8. Date of Bir		Birthplece (State or Foreign Country)
Director			¹ ² √x ^F 5	6 Yrs.	Months Days	Hours N	lin. 8. Date of Bin (Month, Da Aug. 22	2,11947 v	irginia
aryland show		10a. State 10b. County MD Baltimor	1	. City, Town or Lo	Esse	ex			10d. Inside City Limits 1 ☐ Yes 2 🔀 No
h the M or 28a-f a noutifie	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
23a c	ai	415 Delaware A			212:			USA	
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heelth and Mental Hygiene. If of Heelth and Mental Hygiene. Or other the marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 	1	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 XNo		' (Specify Yes or No Jerto Rican, etc.)	Black,	American Indian, White, etc. Ihite
hour	ed b	15. Decedent's Educa		16a. Dece	dent's Usual Occup	pation		16b. Kind of Busin	ness/Industry
within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12th	completed) College (1-4or 5+)		kind of work done DO NOT use retire ffice St			Air Cre	edit Co.
d 2 should be filed within 72 hours aft th and Mental Hygiene. The marked other than "natural", or treumatic event, the Medical Exami	To Be Co	17. Father's Name (First, Middle, Last) Ben Cohn					Name (First, Middle) a Perdue		
and 2 should selth and Men n 27 is marke	-	19a. Informant's Name/Relationship (Type Joseph Bass / h		1			. Baltin		ate, Zip Code)
S 1 and 1 Heel	1 3	20a. Method of Disposition	20	b. Place of Disp	osition (Name of matory or other pla	ce)	Date	20c. Location - Ci	ty or Town, State
Pa ant ury	Ш	1 Burial ZCremation 3 Re 1 Donation 5 Other (Specify)		Bayvie	wCremate	ory 8		Baltimo	
permit. Pages 1 ar Department of Hee Important: If Item any injury or othe		21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications, or heart failure. List only on	Connel	VII	300 MA	ce Ave	. Baltir	more MD	IomeofEssex 21221
eath certificate be executed Example of the continuation and attending physician end for use as the burlat-transit	Icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cor	nsequence of):	and Diaz	zepam II	itoxicatio	on	
0 0	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ses 2 No	c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnanc	у		23d. Date of Month	
hat ad b	by	Part II. Other significant conditions con	nbuting to death but no	t resulting in the	underlying cause gr	ven in Part I.		. /	ute to the cause of death?
The law ate has b page 2 sl	Completed						1 ₽ Yes	psy prior dea	ore autopsy findings available to completion of cause of atb?
	o Be	25. Was case referred to medical examiner? 1XX es 2 □ No	ospital:	2 ER/Outpatie	ot 30 DOA Ot		Death <i>Check onl</i> ng Home XX Resi		(Specific)
	H-1	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Formsd h, Day Yea 8/13/04	28b. Time	of 28c. Inju		Subject	how injury occurred	
el or Attending Ph s after death. al Director: After the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined		At home, farm, s	treet, factory, office		28f. Location (City or To		or Rural Route Number. Delaware Ave.
To the Hospitel or a within 24 hours after To the Funeral Direct completely filled in b	Medical C	29a. Certifier Certifying Phys	ician: To the best of my er: On the basis of exa and manner stated.	/ knowledge, dea mination and/or i	th occurred at the t	ime, date and p opinion, death o		-	ner as stated. d due to the cause(s)
o the ithin 2 o the amplel	Med	29b. Signature and title of certifier	and manner Stated.		29c. Licen	se number		29d. Date signed (Month, Day, Year)
F3F30		Mayine Do	e Youle	m	OCM	Œ		AUGUST	14, 2004
10'		30. Name and address of person who co	mpleted cause of death			reet, E	Baltimore,	Maryland	1 21201
		TILL MATORIA COLON	22. Registrar's						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 800 M Month Day Year **Physician** BLOOM 0 2004 ANNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1405 Bethesda, Monto Suburban MD If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace | State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 21**X**F Days 93 394-28-4518 Nov.5,1910 Milwaukee WI Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 ¥Yes 2 ☐ No MD Montgomery Chevy Chase Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 USA 5555 Friendship Heights filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No 21215-0036 Specify: Specify: þ 3 ₩idowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Food Elementary/Secondary (0-12) College (1-4or 5+) Caterer 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injary or other traumatic event ODCB. Anna Vinograd Julius Sher 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Son 5630 Wisconsin Ave #401 Chevy Chase, MD 20815 Stuart Brafman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 13 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Spring Hill Cemetery Milwaukee, WI 2004 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 9 Physician Ulmonary disease or condition resulting in death) /Medical Due to (or as a consequerce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Be

Division of Vital or Attending Physician: Certification: To within 24 hours after death. To the Funeral Director: A

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Pannie

BLOOM,

examiner? Hospital: 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 X Natural 5 Pending investigation 2 Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

3 Suicide

29a. Certifier

Medical

4 Homicide

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number DXX (\$129

08,09 2004

State

COLE, M.D 31. Date filed (Month, Day, Year)

AHG 1 6 2004

6 Could not be determined

ave, #730 Chevy Chase, MD 5530 Wisconsin 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Voar **Physician** 808 (PM 8 LEHORE Brecht AVGUST 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. Olty, Town, or Location of Death **Examiner** 7. Age (In yrs. last birthday) Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 192–28–6728 **Funeral** Months Days Hours 1 □ M XX F Nov. 14, 1937 Warren, Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show s 23a or 28a-f shoves at the natified at Russell XXYes 2 ☐ No PA Warren Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 88 S. Main Street 16345 USA filed within 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status the Madical Examiner: 1 Yes 2XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "neturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Deli Clerk Quality Markets 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental I shoult: If item 27 is marked o Richard 0. Smith Edna J. Nelson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James T. Brecht / Husband 88 S. Main Street, Russell PA 16345 20b. Place of Disposition (Name of cemetery, crematory or other place) August 12, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ 6 moval from State Warren County Memorial Park 2004 Warren, PA 4 □ Donation 5 □ Other (Specify) Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1501 Fast Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final pespirator **Physician** Adult disease or condition resulting in death) /Medical Examiner cancer unoSequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 📉 No 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2X No 1 Yes 2 No 1 Yes or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ☐ Accident Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide hin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature 0 **RES** 000 MD

State Registrar DHMH 17 Rev 1/2001 N.

Wolfe

Baltimore

30. Name and aldress of person who completed cause of death (Item 23a) (Type, Print) Dr. Ralph Fuchs MD.

600

32. Registrar's Signature

Hospital

ohns Hopkins

State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND ITEM #10a-f PER INF C896/10/212/04/05/21th Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:10pm м July 24,2004 Morrison /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Mariner Health of Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fon Country)
August 29,1917 Brooklyn, NY Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, 5. Social Security Number **Funeral** 1 M 2 ☐ F Days 059-12-5078 86 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show treumatic avent, the Medical Examinar must be nutified at OCALA HD FL 1 XYes 2 □ No Montgomery MARION Dethesda Director 10g. Citizen of What Country? 38th COURT 10f. Zip Code 10e. Street and Number 1812 S.E. ö USA 4925 Battery Lane 2081 4 34471-5644 23a Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural" or item any injury or other treumatic aven. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or Items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Religion Flementary/Secondary (0-12) College (1-4or 5+) Rabbi 5+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Dash Jacob Bial 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 41W. 83RD Street Apt 5C New York, NY 10024 Daniel Bial / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) July 26, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodbridge, NJ Beth Israel Cemetery 2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Foneral Service Licenses Charles L. Stevens Funeral Home Inc 1501 Fast Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Leukemia 1 year **Physician** Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. Il yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ed by the a detached for 9 Unknown ראום nas been signed by t page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes 2 No Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has ! autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? Hospital or Attanding Physician: funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 1 Tyes 1 Inpatient this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0053615 July 24,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan MD 11125 Rockville Pike, Rockville MD AUG 1 6 2004 32. Registrar's Signature State Sporks Registrar

			For State	Sta	ate o	f Marylar	•	rtment o			fental H	ygiene Reg. N	1000	250	20
9			Registrar 1. Decedent's Name (First, Middle	e, Last)							2. Date of D	eath		3. Time	o of Death
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Fune Direc			5. Social Security Number 214–40–0867	6. Sex 1 ☐ M	₩¥F	7. Age (In yrs. 62	Yrs.		ys Hou		8. Date of B (Month, L	bay, Year, [2-4]) 9. BI	thplace (State ountry) MC	
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Re	Sta gistr		31. Date filed (Month, Day, Year AUG 1 6 2004	5	ener	legistrar's Sign	Spirit Sp	ach							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Пач Vear 4:38 P M **Physician** 2004 AUGUST 10 Capino
4b. City, Town, or Location of Death /Medical Francenia Marie 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Doctors Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sax **Funeral** 1 □ M 2 💢 Months Washington, DC 578-80-9090 46 Director 07/03/1958 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State notified at 1 ☐ Yes x2 No Largo Prince George's Maryland Direct 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code ms 23a or 2 20774 USA 10226 Prince Place Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2√ No 1 Never Married 3 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic avant, I'm Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Physicians Office 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be find Mental H marked (Dorothy Marie Goode Gordon Gregory Pridham 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health tem 27 10225 Prince Place T-4 Largo, Maryland 20774 John Capino - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 □ Cremation 3 □ Removal from State 5 ☐ Other (Specify) 08/16/2004 Suitland, Maryland Cedar Hill Cemetery Funeral Send Lice 22. Name and Address Clarifyge P. Kalas Funeral Home PA 21. Signatu 20745 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party. Enter the disease, or complications that shock, or heart failure. List only one cause on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Bilatora Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for s a cons cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ng physician an as the burial-to res a conseq ce of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 menths? ō 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 26 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 CH certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 1 Impatient 2 2 ER/Outpatient 3 DOA His 27. Manner of Death 1 CNatural Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide hours Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Baltimore,	0 0		20a. Method of Di	•	Removal from State	cen	netery, cre	osition (Name o matory or other	place)	Date	di .	on - City or T	own, State
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Bal	permit. Pag Department Important: any injury once.		21. Signature of F	Ineral Service Lice	0				ddress of Facility SON Funer	al Home		O York	Road D 21204
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189	The law requires that the death cartificate to the has been signed by the attending physic page 2 should be detached for use as the top	Physician/Medic	IF FEMALE:			Ü			0	10			
Вох	ath ca ttendi or use	lan/	23b. Was deceded		23c. If yes, outcome	2 Fetal d	death 3	□Ectopic pregn □ Other (specif				Date of deliv Month	ery Day Year
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rds	w requires baen sign should be									1 🗆	Yes 2 No	o 3 🗆 Proi	pably 4 □Unknown
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Diggs Lucretia Y. 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number, NA timore Year If Under 24 Hrs 7. Age (In yrs. fast birthday) 5. Social Security Number

Funeral Director

7 is marked other then "natural", or items 23a or 28e-f show traumatic event, the Mudical Examinar must be multiped at Director Funeral þ and Mental Hygiene. Is marked other then

Pages 1 and 2 should permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau

Maryland 21215-0036

Baltimore,

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Physician /Medical Examiner

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certificate be executed To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is Attending

Physician /Medical Examiner Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Hours 1 ☐ M 2 💢 F 217-60-5272 Yrs 49 Md. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County X☐Yes 2☐No Baltimore Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA 5407 Moravia Rd. Apt. F 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Varies l Yr. <u>Secretary</u> 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Diggs Clara Lopez George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 927 E. 26th Street, Brooklyn, N.Y. 11210 Sean Jordan Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 8-16-04 Dundalk, Md. Mt. Carmel Cem. 21. Signature of Funeral Service Licensee 22. Imme and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East 23a. Part 1. Er er the disease, or complications that caused the de shoot of heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate C use (Final disease or condition resulting in death) Due to (se as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 □ No 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Magner of Death Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Brint) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

6 2004

AUG 1

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 15, 2004 2:50 PM Joanne Amelia Diehl August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Glen Burnie Anne Arundel 1716 Furnace Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 😿 F 62 08/24/1941 MD Director 220-38-6005 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County item 27 is marked other than "netural", or itams 23a or 28a-f show other treumatic avent, the Medical Examinar must be notified at 1 Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 U.S.A. 627 N. Belnord death v Ave. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Importent: if liem 27 is marked other the any injury or other treument. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Childcare Daycare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Frank Dressel Ida May Ruoff ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joyce Dougherty/Daughter 133 Coralwood Rd., Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ■Burial 2 Cremation 3 Removal from State Holy Redeemer Cem 08/18/04 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Dr., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detachad for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown certificate has baan signed rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 Yes 2 No the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{B}$ Other (Specify) 5 n ! s1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Home 27. Manner of Death 28b. Time of 28c. Certification: After 1 X Natural 5 Pending 1 🗌 Yes 2 No investigation 24 hours after death.

Funerel Director: A 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Solow 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 6 2004 Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:42 PM M 80 09 2004 Mary Virginia Emory /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11302 Raphael Road Upper Falls Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Director 215-42-7359 07/11/1917 87 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. inside City Limits r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at Director 1 Yes 2X No Upper Falls Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11302 Raphael Road 21156 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien. Important: If I tem 27 Is marked other the any injury or other traumatic Medical Technologist Medical Laboratory 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Esther McAllister Paul Aime Fleury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Virginia Castro (daughter) 11302 Raphael Road - Upper Falls, Maryland 21156 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐Donation 5 ☐ Other (Specify) St. Stephen Cem. 08/14/2004 Bradshaw, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Tany, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ratus (bres a consequence of): Examiner attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas this certificate 2 No 1 Yes Division of Vital 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 3□ DQA 2 ER/Outpatient 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12625 0 Wilson ms 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

1 100 4. Wilson, Wilson, 2021 Emmorton Rd. Suite 1143, Bel Air MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature AUG 1 6 2004 oaks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 2004 Filbert, Sr. William R. tu gess I /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Hospital of Baltimore Baltimore N/A Sirvai If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Ye June 9, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F Maryland 1924 Director 80 219-18-4429 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State Itam 27 is marked other than "natural", or Itema 23a or 28a-f show other treumatic event, the Medical Examiliar must be notified at 1 ☐ Yes 2X No Directo Timonium Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 U.S.A. 12330 Rosslare Ridge Road #205 Completed by Funeral 12. Was Decedent Ever in U.S. Amped Forces?

1 Xes 2 No
If Yes, Give 1943-1943 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Defense Contract Auditor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Filbert Sophia Tieble Wilson Russell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a Important: if Itam 27 is any injury or other tret ance. 12330 Rosslare Ridge Road #205 Timonium, Maryland Bettemae V. Filbert Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Other (Specify) Hilltop Service Corp. 8-12-2004 Donation Towson Maryland eral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc Towson, Maryland 21204 1050 York Road Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Injuries with complications 1 day Multiple disease or condition resulting in death) But of History Constituted in the second Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Day Month Year in the past 12 months?
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Physician /Medical Examiner

requires that the death certificate be executed

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Completed

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Certification;

Medical

Division of Vital Records, P.O. Box 68760

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Moert, William

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

transplant with immunosuppression

26. Place of Death (Check only one)

24a. Was an autopsy 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

29b. Signature and title of certifier

1 MInpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Augustic, 2004 UM 1 = 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

spect

Motor vehicle accident 28f. Location (Street and Number or Rural Route Number, City or Town State)

29a, Certifier (Check only one)

27. Manner of Death

2 Accident

4 🗌 Homicide

3 Suicide

1 Natural

29c. License number

RES-000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

1600, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

August 11,2004 2401 West Belvedere Avenue 21215

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DHMH 17 Rev 1/2001

To the Hospitel or Attending Physicien:

State Registrar

6 Could not be

determined

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32. Registrer's Signature Apadas ORIGINAL

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	Physician	Decedent's Name (First, Middle, La Alan Dean	Gilbert				2. Dete of Dea Month August	th Day 14,2004		: 35am
1	/Medical Examiner	4a Fecility Name (If not institution, giv				b. City, Town, or l	ocation of Death	4c. County	of Deeth Arundel	
		Crofton Convales 5. Social Security Number 6. S			f Under 1 Year	Crofton If Under 24 Hrs.	8. Date of Birth	1		State or Foreign
H	Funeral Director		M 2□ F 86	Yrs.	Ionths Days	Hours Min.	(Month, Day Sept. 3	,1917	Johnsto	wn PA.
	and	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Locati	ion				10d. Ins	side City Limits
	a-f she	MD Prince G	eorges I	3owie						Yes 2□No
	vith the	10e. Street and Number 3800 Enfield Cha	go Court		10f. Zíp Code 20716		1	10g. Citizen of W USA	/het Country?	
	ms 23c	11. Marital Status	12. Was Decedent Ever in U	,S. 13. Was		ispenic Origin? (S n, Mexican, Puert	pecify Yes or No-	14. Race	e - American Ind	lian,
020	ed within 72 hours aftar death with the Maryland ygiane. It, the Medical Examiner must be notified at it. Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1		Yes 2 No	Specify:	o Alcan, etc.)	Specify	Tilles to	
2-0	72 ho natura dical	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Decedent	t's Usual Occupa d of work done of	ation during most of wor	king	16b. Kind of Bu		
121	within and the Me	Elementary/Secondary (0-12)	College (1-4or 5+)		ounting	,		Accoun	ting	
Maryland 21215-0020	the filed within the filed within the filed with the marked other than natic event, the Market the	17. Father's Name (First, Middle, Last,)				ne (First, Middle, Hochst		е)	
ryla	should to and Mant in marked umatic	Ray R. Gilbert 19a, Informant's Name/Relationship (Type Print)	19h Mailing A	Address (Street	Helen	HOCHST		State, Zip Code,)
	nd 2 sho aith and 27 ia ma r traum	Boyd Gilbert / S					Bowie M			
Baltimore,	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Expanier must be notified at page. To Be Completed by Funeral Director	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State Bay	Place of Disposition cometery, cremato View Cre	ory or other plac	e)	August 1 2004	Baltime	City or Town, Si Ore MD	ate
Baltii	parmit. Pages 1 Department of H Important: If its any Injury or ot once.	21. Signature of Foneral Service Licer		Cl	ame and Addres harles 1 501 East	L. Steve	ns Funer ve. Balt	al Home	Inc.	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal	th. Do not enter the	he mode of dyin	g, such as cardiac	or respiratory arr	rest,	Appro	oximate val Between
>	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Metasta		uno		n Cer			onths
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<u> </u>	execute n and ial-tran	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequer	ice of):				1	
68760,	as that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit by Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (0	or as a consequen	nce of):					
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	na daat tha att thed for thed for	Part II. Other significent conditions of	ontributing to death but not res	sulting in the unde	rlying cause give	en in Part I.				euse of deeth?
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of Vital Records,	raquir						24a. Was e perfor	en autopsy med?	24b. Were aut available completion	prior to on of cause
Re	ysician: The law is cartificate has t director, page 2 s						1 □ Y	es 2 No	1 ☐ Yes	2□ No
/ita		25. Was case referred to medical examiner?	Hospital:		Oth	-	ath (Check only or			
of	Physician: rthis cartific ral director.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of	3□ DOA DON Worl	4 Nursing H	ome 5 Resid			
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completaly filled in by tha funeral di Medical Certification: To	1 Accident 3 Suicide 6 Could not be determined	e San Blace of Injury At h	Injury nome, farm, street, fy)	M 1 🗆	Yes 2 □ No	28f. Location (S City or Tow		er or Rural Rout	e Number,
_	To the Hospital within 24 hours a To the Funeral I completaly filled	29a. Certifier Certifying Pt (Check only one)	nysicien: To the best of my kno nlner: On the basis of examina and manner stated.	owledge, death or ation and/or invest	ccurred at the tim tigation, in my of	ne, date and place pinion, death occu	, and due to the c rred at the time, o	ause(s) and mai late and place, a	nner as stated. and due to the c	ause(s)
	Vithin 2 Fo the comple	29b. Signature and title of certifier	and mainer stated.		29c. Licenso	_		29d. Date signed		
•		Kakesh	CMONG	MD (Type Prin		0108	3	8/1	6104	
	Ĝ	30. Name and address of person who Rakesh Arora MD				D 20715				
	State	31. Date filed (Worth, Day, Year)	32. Registrar's Sign	ature	bouter	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 24a per Verb., G834, 08/12/04-bb 1. Decedent's Name (First, Middle, Last) 2. Date of Death •Physician Month Helen B. Goldsborough July 21 2004 6:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Friends Nursing Home Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 21, 1908 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛣 F Hours 212-40-9421 95 Director New Jersey Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28e-f show 1 Yes 2 No Be Completed by Funeral Director Montgomery Sandy Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 17401 Norwood Road 20860 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other treumatic event, the Madical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced naturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) silversmith jewelry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Levis Miller Booth Alice Lippincott 2 it of Health and N. If item 27 is mai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Sewell/daughter 10213 Claibourne Road Claiborne, MD 21624 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or 4 X Donation 5 → Other (Specify) 21. Signature of Euneral Scryice Licensee Ronal d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Cherspo VA3 wym 3 01741 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner transit requires that the death certificate be executed Due to (or as a consequence of) as the burial Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 2**X** No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) o the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) SUITE LOD, OLNEY MY 20872 Wayer JAULSON, 341- ommuoon m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 12, 2004 **Physician GERBER** 10:10 AM DOROTHY /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE PIKESVILLE 17 TANNER COURT Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, SEPT. 13, 1919 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🗑 F 213-16-5119 84 Vrs MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show traumatic event, the Madical Examinary ust be nutified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 TANNER COURT 21208 Items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0.12 I Hygiene. College (1-4or 5+) HOMEMAKER OWN HOME other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental is marked **JACOB** WOLOCK REBECCA SILVERBERG 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT GERBER / HUSBAND 17 TANNER COURT - PIKESVILLE, MD 21208 f Health other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Deportment of Importent: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 8/13/2004 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiac Amest Physician Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Anteny Disease Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a confequence of): Examiner ng physician and as the burial-transit The law requires that the death certificate be executed 2 Dialustes that initiated events resulting in death) Last (or as a consequence of) Box 68760. Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year ō Month Dav 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. F the 9∏Unknown 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed? res 2 No 2 No 1 🗌 Yes certificate 1 🗌 Yes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes No Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 2 ihis 28b. Time of Injury 28c. Injury at Work? Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D31419 MO, PhO 112/04 of death (Item 23a) (Type, Print) 30. Name and address of person who complete Blud Baltimore, MD David 5 2004^{32. Registrar's Signature} State Registrar

/Medi	ian cal	Decedent's Name (First, Middle, Samuel T. Haddix,				2. Date of Death Month AUGUST	8/7/04 ear	3. Time of Deat
Exami		4a. Facility Name (If not institution, 1200 S. HANOVER		4b. (City, Town, or Location of Dea BALTIMORE C		4c. County of Deat	th
Funeral Director		5. Social Security Number 218–02–8064 Usual Residence of Decedent	6. Sex 1 ★ 2 ☐ F 7. Age (In yrs. 37	last birthday) If U Yrs. Mon	nder 1 Year If Under 24 Hr hths Days Hours Mir		Year) 9. Birt Co	thplace (State or Fore buntry) MD
or 286-f show	tor	10a. State 10b. County N/A	10c. Cit	y, Town or Location	Baltimore City			10d. Inside City Lim
rms 23a or 28e-f show	al Director	10e. Street and Number 1435 Decatur Street		101	f. Zip Code 21230	10	g. Citizen of What Co	puntry?
Department of Hanks and Mental Hygiene. Importent: if Item 271s marked other then "neturel", or Items 23s or 28e-f show eny injury or other treumetic event. It is Madical Examination as Item 21s once.	by Funeral	11. Marital Status 1 XXIever Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 TNo If Yes, Give Year or Dates:	1	ecedent of Hispanic Origin? (specify Cuban, Mexican, Puess 2 No Specify:	Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White Specify: To	
n "netur	Completed	15. Decedent' (Specify only highest	grade completed)	(Give kind o	Usual Occupation of work done during most of w OT use retired)	orking 1	6b. Kind of Business/	Industry
ygiene. ner ther	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	Cont	tractors Helper			ruction
Mental H arked ott etic even	To Be	17. Father's Name (First, Middle, L Samuel T. Haddix,				ame (First, Middle, M L. Frampton	aiden Sumame)	
alth and 27 Is ma		19a. Informant's Name/Relationsh Evelyn L. Haddix /			dress (Street and Number or F Tur Street, Balti			Zip Code)
t of Hear If Item or othe		20a. Method of Disposition **Durial 2 Cremation	3 □ Removal from State	Place of Disposition cemetery, crematory	or other place)		0c. Location - City or	
intmen ortent: njury	П	' 4 □Donation 5 □ Other (Sp	001.97	udon Park Os			Baltimore Ma	iryland
Depa Impo eny it		21. Signature of Funeral Service L	P. Loca	darle	es L. Stevens Fun East Fort Avenue,	eral Home, I	nc.	
/Medical xaminer	ner	resulting in death) Sequentially list conditions.	Due to (or as a conseq	uence of):				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** COCKEYSVI BROAD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Min 212-40-5894 1 ☐ M 2 🔀 F 91 Director 12. 1912 Nebraska Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Baltimore Cockeysville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 13801 York Road 21030 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: white 2 3√□ Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. baltimore county Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary public health officer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 99 if Health and Mental Charles Jameyson Hannah Tow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Kathy Nicolls/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ō 1 Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or gages. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Euneral Service Licensee tate Anatomy Board 655 W. Baltimore Street altimore, MD 21201 Baltimore, MD ran 23a. Part i Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a conso ue ce of) Examiner the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use conflibute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Medical Certification; To 28c. Injury at Work? 27, Manney | Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Linatural 5 Pending 1 TYes 2 🗌 No investigation 2 ☐ Accident Director Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 1 L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier ed cause of death (mm 23a) (Type, Print) 2. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 6 2004 Registrar

Helen

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		•	For State Registrar	State of	Maryland	•	artment of H rtificate of I			giene Reg. No.	04	25644
	hysicia Medic	an	1. Decedent's Name (First, Middle, Las JAMES HE.	NSON			\ ·		2. Date of De Month		2004	3. Time of Death
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	neral ector		212-70-7911	9x 7. ▼ M 2□F	Age (In yrs. I.	ast birthday) Yrs.	ff Under 1 Year Months Days	If Under 24 H Hours Mi		th ly, Year) 1912	Cou	place (State or Foreign intry) th Carolina
anyland	N To		Usual Residence of Decedent 10a, State 10b, County MD		10c. City	, Town or Lo	cation Ltimore					10d. Inside City Limits 1∑ Yes 2 ☐ No
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Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene.	o Medical E	Completed	15. Decedent's Ec (Specify only highest gra	ucation		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of w	vorking	16b. Kind of E		
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Mary	r traume		19a. Informant's Name/Relationship (Paulette Scotland		ver		ng Address (Street a Altamont					
Baltimore, sermit. Pages 1 at Department of Hea	Importent: If tem 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ∰ Other (Specifi	Removal from St	20b. Pl	ace of Dispo	sition (Name of natory or other place		Date	20c. Location		
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Division of Vital Records, to Attending Physician: The law requires if effer death.	page 2 sho	Completed	H						24a. Was autoj perfo 1 🗆 Yes	osy ormed?	Were auto prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of 2 No
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sion of ending Ph eath.	Io the Funeral Director: Alfar fris certificate has completely filled in by the funeral director, page 2	Certification: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of (Month,		28b. Time of Injury	f 28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe			<i>y</i> /
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To t	moo moo	Σ	29b. Signature and title of certifier Invest V - M	oph beli	mo			1949		29d. Date sign	•	Day, Year)
111,2			30. Name and address of person who	completed cause	of death (Item	23a) (Type,	Print) אניקטר האלי	W.BA	MD &	1773	ET	
F	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 6 2004		gistrar's Signa	ture						

			1 - State	artment of Health and Men		0001
			Registrar 1. Decedent's Name (First, Middle, Last)	2.1	Reg. N	3. Time of Death
	Physici /Medio		MAGARET E. HILLEGAS		Month JGUST	10 2004 10:00 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	tc. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	A WELPH 1 If Under 1 Year If Under 24 Hrs. 8. p		9. Birtholace (State or Foreign
	Director		173-24-6550 10M 20F 93 Yrs.	Months Days Hours Min.	Date of Birth Month, Day, Yea EB 15	9. Birthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Mary a-f sh	ţoţ	MO CARROLL SYA	ESVILLE		1 ☐ Yes 2 No
	or 28	Direc	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	eath w	Funeral Director	6683 Slacks Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Deceded of Historia Origina (Secretary	Voc or No	USA 14. Race - American Indian,
စ	after d		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ★ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	n, etc.)	Black, White, etc.
003	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show he Medical Evaminer must be notified at	d by	3XX Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White
15-	in 72 l	olete	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)		Kind of Business/Industry
21215-0036	d with giene. er thau	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	RETARY	A	DUENTIST HOSPITAL
	be file ital Hy id oth event	To Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (Fir	st, Middle, Maide	en Sumame)
Maryland	should nd Mer marke umatic	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	marcare ing Address (Street and Number or Rural Ro		t RROMan
	alth ar alth ar 27 is				suille ?	
Baltimore,	permit. Pagas 1 and 2 should be filed within 72 hours after death with tha Marylan Department of Health and Mental Hygiene. Important: If I tem 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at ances.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place)		Location - City or Town, State
Ē	permit, Page Department Important: If any injury or once.		'4 □Donation 5 □Other (Specify) Memo CA	ematory, Tuc 8/11/00	f Ba	Himore, mo
Ba	Depa Impo any it	J.,	21. Signature of Funeral Service Licensee	2. Name and Address of Facility J. W.	ZUMBA	SCULLE MA 21754
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	DEMENTIA		Onset and Death
	/Medical Examiner		a			
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	acuted and transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	cate be exacuted physician and the burial-transit		Due to (or as a consequence of):			
9	lificate g phys as the	Physician/Medical	d			
Вох	th cert tendin or use	an/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery
0.	The law requires that the death certificate has baen signad by the attending page 2 should be detached for use as:	ysici		Other (specify)		Month Day Year
<u>a</u>	res that tignad by	by Ph	Part II. Other significent conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	w requires baen sig should be	ted b	Hypertension		1 ☐ Yes	2 XNo 3 □ Probably 4 □Unkn <i>o</i> wn
ecc	e 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E	n: The ficate or, pag	e Cor	25. Was case referred to medical		performed? 1□ Yes 2 N	death? 0 1 ☐ Yes 2 ☐ No
f Vital	ysicia is certi directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatier	26. Place of Death Chart Other: 4 Nursing Home		6 ∏Other (Specify)
0 0	ing Ph	L:uo	27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		Describe how inju	
Division of	Attending Physician: r death. ector: After this certificiby the funeral director.	licat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	ocation (Street a	and Number or Rural Route Number,
<u>≥</u>	at or A s after il Direction by	Certification;	4 Homicide determined 288. Place of Injury - At nome, farm, st building, etc. (Specify)		City or Town, Sta	(e)
	To the Hospital or Attending Physician: The lawinhin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deat 2 Medicel Examiner: On the basis of examination and/or in and manner stated	h occurred at the time, date and place, and d vestigation, in my opinion, death occurred at	ue to the cause(s	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2. To the complet	Med	one) and manner stated. 29b. Signature and title of certifier.	29c. License number		ate signed (Month, Day, Year)
ļ	/		Moralthano	06053337		GUST 10,2004
	h	C	30. Name and address of person who completed cause of death (Item 23a) (Type,		In:	md
	Sta	te	31. Date filed (Month, Day, Year) 32 Aegistlar's Signature	- summy	geri	y in.
	Registr	- 3	AUG 1 6 2004 Januar St. Ag	ed		

4-	-05260		Plea	se Type or Prir								Legible.	
PI)	1 - For State of Maryland / Department of Health and Mental For Certificate of Death						nental Hy	/giene	001.	2561.6		
ı	Division		Decedent's Name (First, Middle	e, Last)						2. Date of D	eath		3. Time of Death
	Physici /Medio	al		AE IM			45 0% 7	F	Location of Death	Augus		2004 ^{ear}	0220 Ам
	Examin	er	4a. Facility Name (If not institution 1900 North Ber	_	-				nore		40. (County of Deat	
l	Funeral Director		5. Social Security Number 216-88-3266	1444	e (In yrs. last bi	irthday) Yrs.	If Under ' Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D 06-12	rth ay, Year) -1943	9. Birt Co K	hplace (State or Foreign untry) OREA
	yland Jow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	wn or Lo	cation						10d. Inside City Limits
	he Mar 8a-f sl	Director		TIMORE					ILLE				1 □ Yes 2√QNo
	h with t	al Dir	10e. Street and Number 9378 PANRID	GE ROAD			10f. Zip (1234		10g. Citiz	zen of What Co KOREA	untry?
350	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Esa: if ar culant be colified at	by Funeral	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced				Was Decede If Yes, speci 1 ☐ Yes		ispanic Origin? (Spanic Origin?) In, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	1	14. Race - Ame Black, White Specify:	
215-0036	72 hou natura	eted	15. Deceden	t's Education st grade completed)		a. Deced	dent's Usual	l Occup	ation during most of wor	kina	16b. Kin	nd of Business/	Industry
	within ene.	Completed	Elementary/Secondary (0-12) 12 YEARS	College (1-4or 5		life. I	NO NOT use	e retired	OPERATOR		GRO	CERY S	TORE
Maryland 2	d d d d	To Be (17. Father's Name (First, Middle, CHANG HO IM	Last)					18. Mother's Nan	ne (First, Middle CHOON	, Maiden S KWON		
lary	2 should and Men Is marke raumatic	. 7	19a. Informant's Name/Relations				_		and Number or Ru				
	of Health item 27		DOMINIC S. IM 20a. Method of Disposition	(SON)	20b. Place	of Dispo	sition (Nam	e of	WOODS COL	JKI, VI Date		VIRGINI cation - City or	
Baltimore,			XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State Specify)	DULAN		natory`or oti /ALLEY		00 10	-2004	TIM	ONIUM,M	D.21093
Ball	permit. Page Department Important: II any injury o		21. Signature of Funeral Service	Licensee					ss of Facility N FUNERAL	HOME.	TNC.		ORK ROAD , MD.21204
60,	Physician and // // // // // // // // // // // // //	cal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. HYEATI Due to (or as b. Due to (or as c.	ne.	Ard of):			20716 (H			DISCALÈ	Approximate Interval Between Onset and Death
O. Box 687	The law requires that the death certificate be the has been signed by the attending physicionage 2 should be detached for use as the binage.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal deat		Ectopic pre		,		2	23d. Date of del Month	ivery Day Year
JS, P.	ires that the de signed by the a be detached t	by	Part II. Other significant conditi	ons contributing to death b	ut not resulting	in the u	nderlying ca	ause giv	en in Part I.				the cause of death?
Division of Vital Records,		Completed								24a. Wa		24b. Were au	stopsy findings available completion of cause of
<u> </u>	ysician s certifi director	To Be	25. Was case referred to medica examiner? 1 ∑ Yes 2 □ No	Hospital:	ent 2 ER/C	outpatier	nt 3 DO	A Oth	26. Place of Dea er: 4 ☐ Nursing H			S Nother (Spe	eify) At Scene
ion of	<u> </u> = ∞		27. Manner of Death 1 Natural 5 Pending investing investing 5 pending investing inves	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury		8c. Injun Wor		28d. Describe			ny) 110 230170
Divis	al or Attendent after death	Certification	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of Inj	ury - At home, c. (Specify)	farm, str	reet, factory,	, office		28f. Location City or To	(Street and own, State)	d Number or Ru	iral Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifyi (Check only one)	ng Physician: To the best Examiner: On the basis o and manner st	f examination a	ge, deat	h occurred a vestigation,	at the tin	ne, date and place pinion, death occu	, and due to the rred at the time	e cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certific	ar T					e number			e signed (Monti	
•			> U	NETC				C.M	. Ľ.		Aug	ust 14,	2004
	10		30. Name and address of person	A RUSIU,	MO,	,	111 P	enn	Street,	Baltim	ore, l	Marylan	d 21201
	St Regist		31. Date filed (Month, Day, Year AUG 1 6 2004	Se 32. Registr	rar's Signature	Sp	als						-

DHMH 17 Rev 1/2001

ysicia	210	Decedent's Name (First, Middle, Last	t)						2. Date of De	eath Da	av v	ear	3. Time of Death	
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amin		4a. Facility Name (If not institution, give			,		Location of			4	c. County of	Death		
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eral		5. Social Security Number 6. Se 215–22–5298	TH ONE	(In yrs. last birthday	Months	Days	Hours 2	Min.	8. Date of Bir (Month, Da	ay, Year	9.		ace (State or Foreign try)	
ctor		Usual Residence of Decedent	9:	5 '''					9–21-	- 08		T	enn.	_
14		10a. State 10b. County	1	10c. City, Town or L	ocation							10	Od. Inside City Limits	
pag	ģ	Md. NA		Ral+	imore								1 X Yes 2 □ No	
1	Directo	10e. Street and Number		Dare	10f. Zip	Code				10g. C	itizen of Wha	at Coun	try?	-
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	o Be	Elias		Reed				ila	,,			wmar	1	
other traumatic	은	19a. Informant's Name/Relationship (T	vpe, Print)		ling Address	(Street ar			l Route Numb	er. City				
rtran		Ethel Mae Mitche			_				Baltim	-		212		
othe	- 3	20a. Method of Disposition		20b. Place of Disp	osition (Nan	ne of			ate		ocation - Cit			-
ō		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)		Md. Nat.	. Mem.		·	8-12	2-04	T.a	aurel,	Md		
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		shirck, or heart failure. List only of	one cause on each line.	/ /									Interval Between Onset and Death	
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			For State	State of Marylar		ite of Death		0001	05610
	6 A		Registrar 1. Decedent's Name (First, Middle, La	est)	Octunica	ne or beam	Reg. N	10.	3. Time of Death
	Physicia	an	E in a	· Ande	Son			Day Year	21 dille
2	/Medic	200	4a. Facility Name (If not institution, gin	ve street and number)		y, Town, or Location of Dea		4c. County of Death	4 0,00
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24 F	uneral	-		Sex 7. Age (In yrs.		er 1 Year If Under 24 Hr		9. Birthp	lace (State or Foreign
1000	irector		420-40-2310	10 M 201 92	Yrs. Month	s Days Hours Min	MARSI	912 ALA	-hama
g.	_		Usual Residence of Decedent	10.0	-		7	1.	Od. Inside City Limits
aryla	a hoy	<u></u>	10a. State 10b. County	1.	ty, Town or Location			'	1 PYes 2 □ No
he M	Se-f	Director	111d. 1011	T)/7/11/n	ORE	100 /	Citizen of What Cour	
with t	N S	ā	10e. Street and Number	FEA At	101. 2	Zip Code	109.	I d	luy?
death with the Maryland	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	IS 13 Was Dec	cedent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	an Indian.
ter	in the	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	If Yes, s	pecify Cuban, Mexican, Pue	rto Rican, etc.)	Bfack, White,	etc.
-0036 hours after	al', o	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify:	ACK
5-0036	Detur	Completed	15. Decedent's E (Specify only highest gr		16a. Decedent's U:	sual Occupation work done during most of we		Kind of Business/Inc	dustry
-2121: within 72	e e	nple.	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life. DO NOT	use retired)	0		Tolle
N D	ther th	Con			DomE	STIC	PR	-IVATE	77m1116
and d be file	dot	Be	17. Father's Name (First, Middle, Las	<u>0</u>		18. Mother's Na	me (First, Middle, Maid	en Sumame)	
	narke natic	ို	EliAS JA	ekson		DUS	IE KAL	1ER	
Mary d 2 shou	is rr		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addre	ss (Street and Number or F	dural Route Number, City	y or Town, State, Zip	Code)
	n resum and when rygener and proper of thems 23s or 28e-f show them 2 is marked other than "netural", or itsems to other traumatic event, the Modical Examiner must be notified at		20a. Method of Disposition	FOPE 20b.	Place of Disposition (A	IERESA C	Date 20c.	Location - City or To	own State
Baltimore, Dermit. Pages 1 ar	_ = 5		1 Burial 2 □ Cremation 3	☐Removal from State	cemetery, crematory p	r other place)	10 ch	11 Im	, otato
tin t Pa	Important:		*4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lies	/ 7.0	-/Change	and Address of Facility	10/2004 DA	113 VIV	SIN PA
Balt permit.	lmp any once		21. Signation of Furieral Service Like	dans	2.	25/12/2	JONES -	A A	n. Sve lit
	The said		23a. Pari 1. Enter the disease, or con	nplications that caused he dea	th. Do not enter the m	ode of dying, such as cardia	ac or respiratory errest.	0177101	Approximate
			shock, or heart failure. List only Immediate Cause (Final	y one cause in each fine.	Luca	1-11	i. Cart	14	finterval Between Offset and Death
	ysician Iedical		disease or condition resulting in death)	a. Due/b (or as a consec	y a	ray "	Juliet !		clows
	aminer			a les	duence oi).	ent de	· Jesenz	_ ' '	nay
Park.	71	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):				f
petri	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	HUD	erlees	·an			"Teal)
760, te be executed	sician and burial-transit		resulting in death) Last	Due lo (or as a con lec	quence of):				1
1760 Ite be e		cal	•	_ d					
rifficat	ng ph astt	Med	fF FEMALE:						
XO #	tendi or use	an/I	23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		pregnancy		23d. Date of delive Month	Day Year
P.O. Box	he at led fo	200	in the past 12 months?	4□Pregnant at time of o	death 5 Other	(specify)		WORTH	Day 16a
P.C	been signed by the attending phy should be detached for use as th	Physician/Med	9 ☐ Unknown Part II. Other significant conditions	contributing to death but get re-	nulting in the underhan	s enues awas in Part I	23a Did tobaco	o use contribute to the	ne cause of death?
Records, he law requires tl	signe b ed t	þ	Partii. Other significant conditions	contributing to death but not re-	sulling in the underlying	g cause given in Faith.	1 ☐ Yes		
Orc Pegu	hould	Completed							
Sec B law	has t	дı					24a. Was an autopsy performed?	prior to co	psy findings available mpletion of cause of
<u> </u>	cate . pag						1 Yes 2		2 □ No
Vital sician: T	certif	Be	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only one)		-
Phys	r this	۲. ۲.	1 ☐ Yes 2 ☑ No 27. Manner of wath	1 Inpatient 2	ER/Outpatient 3 28b. Time of	JOA 4 Jursing	Home 5 Residence 28d. Describe how in		r)
Ou	h. After fune	ţ	1 ENstural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		je., 200000	
Division of	ctor:	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At h	nome, farm, street, fact		28f. Location (Street		il Route Number,
	Dire	Certification;	4 Homicide	building, etc. (Speci	ify)		City or Town, St	ate)	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifical	within 24 hours after death. To the Funeral Director: After this certificate has completely filted in by the funeral director, page 2		29a. Certifier 1 - Certifying P	Physician: To the best of my kn	owledge, death occurre	ed at the time, date and place	e, and due to the cause	(s) and manner as s	ated.
he Ho	n 24 I he Fu	Medical	(Check only 2 Medical Exa	aminer: On the basis of examination and manner stated.	ation and/or investigati	on, in my opinion, death occ	curred at the time, date a	and place, and due to	the cause(s)
Tott	To ti	ž	29b. Signature and title of certifier		2	9c. License number	29d. [Date signed (Month,	Day, Year)
	~		MANNA	Ci & WAD		10835	8 4	ug 14	1 5007
			3 Name and address of person who	10 /		8903 H.	407000	(A) 1)	- 61
	177		4CKainy.		10	BACT	MARICA	10 3/2	23 4
	Sta Registr		31. Date filed (Month, Day, Year) AUC 1 6 200	2. Registrar's Sign	ature				

State of Maryland / Department of Health and Mental Hygiene

					Olulo of	war y lario		tificate of			Reg. No	ខ្ ខ្ពព	The state of the s	2561.9
	<u></u>	_	1. Decedent's Name		ist)					2. Date of De Month	eath Da	E O	Year	3. Time of Death
	Physiciar /Medica	_		Alan	Mich	ael		Jubb_		Augus				2:30 P.M
	Examine		a Facility Name (I	not institution, giv	e street and numb	ber)			4b. City, Town, o	or Location of Dea	th 40	. County	of Death	
		н	H.C.R.	Manor (Care				Middle	River		Balt	imo	re
	Funeral		5. Social Security N	umber 6.	Sex 7.	. Age (In yrs. la	st birthday)	If Under 1 Yea Months Days	r If Under 24 H	rs. 8. Date of Bi in. (Month, D	rth ev. Year)	9. Birtho	lace (State or Foreign
- 0	Director	1	212-60-	3838	1 √ M 2□ F	51_	Yrs.	WOTHING Days		10-21				yĺand
	P .		Usual Residence of			40.00	T							0d. Inside City Limits
	show	ال	10a. State	10b. County			Town or Lo						'	1 Yes 2 No
	the Ma		Maryland				Balt	imore						21
	4 2 2 3	2	10e. Street and Nur	nber				10f. Zip Code		_		itizen of W		ntry?
	23a	<u> </u>	3226 Fa	ait Ave				<u></u>	2122			U.S.		
	72 hours efter death with the Marylend natural', or items 23e or 28e-f show stell Examiner must be notified at	runerai Directo	11. Marital Status		12. Was Deced Armed Ford	es?	. 13. V	Vas Decedent of Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-		i - Americ c, White,	an Indian, etc.
0	or it		4.5	ed 2 Married	1 ☐ Yes 2 If Yes, Give			☐Yes 2XN	o Specify:			Specify:	Wh	nite
21215-0020	Len.		3 Widowed		Year or Date	es:					1 101 1			
7	721 natu	Completed	(Spec	 Decedent's E ify only highest gr 	ducation ede completed)		16e. Deced	ent's Usual Occi	upation e during most of v ed)	vorking	16b. F	Kind of Bu	siness/Ind	dustry
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	lygie her ti	ริ -	12	(First Middle Lee						lame (First, Middle				- 1
ũ	d off	וֹ מֿ	17. Father's Name (John			ubb S	r.			ude Ire				stein
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Ö	ges 1 e t of Hei or othe		20a. Method of Disp 1 ☐ Burial 2 [Removal from St				ace)	8-18-04				
Baltimore,	nit. Page ertmant o ortant: if injury or			5 ☐ Other (Speci		Gre				0-10-0	Du	I (III	OIC	,
ä	appending to the control of the cont		21. Signature Fu	peral Service Lice	nsee			Name and Add		ino Jr.	F	uner	al	Home
ш	205 2 3	1	pa	N/	Dance	W.		263 S.	Conkli	na St.	Bal	to.	Md.	21224
			23a. Part1. Enter the shock, or hea	ne disease, or con	plications that cau	used the death.	Do not ent	er the mode of d	ying, such as card	liac or respiratory	arrest,			Approximate Interval Between
	Physician .		Ondon, of nou										1	Onset and Death
	/Medical		Immediate Cause (Final	Mus	mrd	ia l	In	Farest	,iW				
1	Examiner	-	disease or condition resulting in death)		a	Due to (or	as e conseq	uence of):	Faret	0			1	
	The state of the s	Ē			Con	Oaru	Art	dry	Dis00	02)				
	law raquiras that the death certificeta be executed as been signed by the attending physician and a 2 should be datached for use as the burial-transit	Medicai Examiner	Sequentially list con	nditions,	b. <u>90 5 %</u>		as e conseq						i	
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89	tifice ng ph as ti		resulting in death) i	-asi									1	
Вох	attendir for use				d									
	deat e att	Completed by Physiciany	Part II. Other signif	icant conditions	contributing to dea	th but not result	ting in the ur	nderlying cause o	given in Part I.	23b. Did	tobacc	o use con	tribute to	the cause of death?
P.0	t the de by the a tached	۱څ		Cto or	0	0 200	200			1□	Yes	No.	3 🗆 Prol	bably 4 ☐ Unknown
	as tha igned be da	اج	ind	orape	llena	x ve	YUN)		_				
ĕ	v raquira: been sig should b	8		•						24a. Wa	s an auto	opsy	24b. W	ere autopsy findings ailable prior to
ပ္ပ	w rak			10 000						-	omioa:		co	mpletion of cause death?
Re	0 - 6	Ĕ								1-	V=4 0	Line	1 []Yes 2□No
Division of Vital Records,	iclan: The law cartificeta has l rector, paga 2 &	٥	25. Was case refer	red to medical					26 Place of F	Death (Check only	onel	7		
Ē	carti	ם מ	examiner?		Hospital:	patient 2 🗆 E	R/Outpatien	t 3 DOA	What !	Home 5 Res		€ □Othe	r (Specif	
of	Phys this ral di	0	27. Manner of Deat				28b. Time of			28d. Describe				γ/
-C	eath. or: After the funer	ē	Natural	5 Pending investigation	28e. Date of (Month)	, Day Year)	Injury		7onk? □Yes 2□No			•		
: <u>S</u>	Attending Physician: or death. ector: After this cartific by the funeral director,	20	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not I	00 Diago	of Injury - At hon	ne. farm. str	eet, factory, offic		28f. Location	(Street a	nd Numbe	er or Rura	al Route Number,
<u>></u>	or A after Direction by		4 🗆 Homicide	determined	building	g, etc. (Specify)	,,	oot, tablety, onto		City or To				
	ours and illed	edical Certification:	29a. Certifier	Cartifiana D	hysiclan: To the b	and of my know	ladae death	occurred at the	time date and pla	on and due to the	021160/	c) and mai	nnar ac c	totad
	Hospital 24 hours Funerel staly filled	<u>8</u>	(Check only one)	2 Medicai Exa	miner: On the bas	is of examination	on and/or in	estigation, in my	opinion, death of	courred at the time	, date ar	nd place, a	nd due to	the cause(s)
	To the Hospital or Attendwithin 24 hours after deati		29b Signature and	title onsertifier	and marine	, o.u., ou.		29c. Lice	nse number		29d, D	ate signed	(Month.	Day, Year)
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			JIM		riker	·,M.	<u>い</u>		5697	7	211	MU	7	11061
1			30. Name and addr	ess of person who	, /	of death (Item	23a) (Type,	Print)	1 RD S		01-	n B	10/0	21061
Ч_			Madai		aun	7845		1CMDD0	x KD J	TE IDD	الماص	n Ø	uyr	NE MD
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	Registra		AUG	1 6 2004	A State Land	5 A 100	Grade							
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DHMH 16 Rev 6/95

			1 - For Amend Item Registrar		f Maryla per T	nd/Dep	artment 34 08/ rtificate	167	ealth a Déath	and N	lental H	ygien Reg. N	e 2 N N		256	50
	Physici	an	1. Decedent's Name (First, Middle,	•							2. Date of D	Death D	ay_	Year	3. Time o	f Death
П	/Media	al	Juanita Y. Ki 4a. Facility Name (If not institution,				41.00			. =	Augus	t 6,	^{ay} 2004		11:53	3 PM ^M
	Examir	er	Gilchrist Hos	•	moer)		4b. City, T	own, or Limo		or Death		4	c.County Balt		0	
	Funeral			i. Sex	7. Age (In yrs	. last birthday)	If Under 1	Year	If Under		8. Date of E	lirth				or Foreian
	Director		410-54-9253 Usual Residence of Decedent	1□M 2X)F	68	Yrs.	Months	Days	Hours	Min.	Apr 10), 19	36	Ten	place (State of try)	
	hours after death with the Maryland turel', or Items 23e or 28e-1 show of Exaciding Frant be motilied at	_	10a. State 10b. County	1	10c. C	ity, Town or Lo								1	0d. Inside C	•
	8e-f	cto	MD Howar	d 		Colu	mbia								1 □ Yes	2X No
	ath with the Marylan s 23e or 28e-f show ust be notified at	Funeral Director	10e. Street and Number 5860 Stevens Fo	moot Dee			10f. Zip (10/5			10g. C	itizen of W	hat Cour	ntry?	
	leath	era	11. Marital Status		dent Ever in U	J.S. 13 1	Was Decede		1045	gin? (Sn	ecify Ves or N	lo-		SA	an Indian.	
٥	after o	Fun	1 Never Married 2 Married	Amed Fo	rces? 2 ⊠ No						ecify Yes or N Rican, etc.)	.0-		, White,		
200	rel', c	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	/e ates:		1 ☐ Yes 2.	X) No	Specify:				Specify:	b1	.ack	
7	72 h "netu	etec	15. Decedent's (Specify only highest)			16a. Dece	dent's Usual kind of work DO NOT use	Occupa done d	ition u <i>ring</i> mos	t of work	ing	16b. l	Kind of Bus	siness/In	dustry	unk
21215-0036	J within 72 hours after dea jiene. r then "neturel", or Items I'm Medical Exer. in et i'n	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		DO NOT use									
2	s filed within 72 h I Hygiene. other then "netu rent, tre Medice		17. Father's Name (First, Middle, La	ist)		50	curre	<i>y</i>	18. Mothe	r's Name	e (First, Middl	e. Maidei	n Sumame			
<u>a</u>	lid be lental rked (o Be	Alfred Hill								ne Iro				ns	
Maryland	es 1 and 2 should be filed of Health and Mental Hygis f item 27 le marked other r other treumatic event, II.	_	19a. Informant's Name/Relationship Pamela Anita Pamela Stilee/d	(Type, Print)		19b. Mailir	ng Address (Street a	nd Numbe	or Rura	al Route Num	ber, City	or Town, S	State, Zip	Code)	
∑	s 1 and 2 of Health a item 27 le other tree			aughter		5860	Steve	ens	Fores	st Ro	oad Co	Lumbi	la, M	0 21	045	
Baltimore,	ges 1 t of Hi If iter		20a. Method of Disposition 1 Burial 2 Cremation 3	☐Removal from	/ H	Place of Dispo cemetery, cren	sition (Name	e of			Date		ocation - 0			
	t. Pag tment rtent: njury		° 4 XDonation 5 D Other (Spe	city)	_ /											
ga	permit. Pages Department of I Importent: If ite eny injury or or <u>once.</u>		21. Sign that theral Serve Lice Ronald S	Wade,	irecto	$z = \int_{0}^{2} t$	Name and ate A	Addres:	s of Facilit my B	y oard	655 W	. Ba	ltimo	re S	treet	
	-hysician		23a. Part 1. Enter the disease, or co shock, or heart failure. List or Immediate Sause (Final disease or condition	ny one cause on e	ach line.			of dying	, such as		or respiratory				Approximate Interval Bette Onset and I	ween
	/Medical		resulting in death)	a Due to (or as a conse	quence of):	14061	100		7	0 (367	26			Jean	ر حا
	Examiner	_	Sequentially list conditions,	b												
	hed Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or injury	Due to (or as a consec	quence of):										
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9/60	re be (lical		d.												
20	certificate be executed iding physician and ise as the burial-transi	Medi	LIE EGILLIE													
o n	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant	23c. If yes, out 1□Live b	come of pregnirth 2 Feta		Ectopic pred	nancv					23d. Date		,	
	ne death the atten hed for u	/sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregn 9□Unkno	ant at time of o	death 5	Other (spec	city)					Mont	n	Day Y	/ear
ŗ.	that the ed by th detache		Part II. Other significant conditions	s contribution to de	eath but not res	sulting in the ur	nderlying cau	ISB CIVE	n in Part I		23a Did	tobacco	use contrib	oute to th	e cause of d	oath?
	requires t reen signe hould be	d by	Dancientic	MASS	au Dat Hot To	suming with the di	idenying cac	ise give	i i i i i i cai ci.						ably 4 🗆 U	
ecords	w req been shou	lete									24a. Was					
r	sician: The law s certificate has b lirector, page 2 sl	Completed			-						auto perf	ipsy ormed?	pri de	or to con ath?	esy findings a apletion of ca	luse of
	an: T tificat tor, pa	a	25. Was case referred to medical	1					26 Place	of Death	1 Yes	2⊠No	1 [Yes	2 No	
= :	iysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2] ER/Outpatien	t 3 DOA				ne 5□Res		6 DiOther	(Specify	400	C 12
0 -	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of	of Injury h, Day Year)	28b. Time of	280	. Injury Work	at ?		28d. Describe					
VISION	tendii eath. or: A the fu	catio	2 Accident investigat	ion			М	1 🗆 Y	es 2 🗆 N	10						
<u> </u>	or Ati	Certification;	3 Suicide 6 Could not 4 Homicide determine	ed 289. Place	of Injury - At h	ome, farm, stre fy)	eet, factory, o	office		2	28f. Location (City or To	Street ar wn, State	nd Number a)	or Rural	Route Numb	er,
_	spitel ours a nerel filled		29a, Certifier 1 Certifying	Physician: To the	best of my kno	owledge death	occurred at	the time	date and	t place s	and due to the	021120/5	and man	205.00.00	tod.	
:	e Hos 24 h e Fur letely	edicai	(Check only 2 Medical Ex	aminer: On the ba and mann	isis of examina	ation and/or inv	estigation, ir	n my opi	nion, deat	h occurre	ed at the time,	date and	place, an	d due to	the cause(s)	
:	To the Hospitel or Attending Physician: within 24 hours alter death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Me	29b. Signature and title of certifier	1 2			1	License					te signed (
			If Anthon	Mily,	no		1)=	250	205			Aug	UST ?	7,20	00 k	
			30. Name and address of person wh	o completed caus	e of death (Iter	т 23a) (Туре, I И_ С	Print)	pro.	R	0						
			W.A. Riley	GAMC	6701	N. Ch	larle.	1	. Ba	lto	md.	212	0/2			
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 6 2		egistrar's Signa	A A	22									

			State of Marylan	•	nt of Health and te of Death		giene _{Reg. No} 2 ()	04	2565L
		1. Decedent's Name (First, Middle, Last)			2. Date of De Month	eath Dey	Year	3. Time of Death
	Physician /Medical	Josephine Mig	liaccio			August		2004	6:30 PM
	Examiner	4a Fecility Neme (If not institution, give	street end number)		4b. City, Town, o	or Location of Deet	h 4c. Count	y of Deeth	
		Franklin Square	Hospital		Rossv	/ille		timore	
	Funeral	5. Social Security Number 6. Se	7. Age (In yrs.	lest birthday) If Und	or 1 Year If Under 24 H Days Hours Mi		th y, Year)	9. Birthplac	e (Stete or Foreign
	Director	073-18-8632	□M 2×F 8			01-21	-1924	New Y	
	p .	Usual Residence of Decedent	100 Ci	y, Town or Location				10d	. Inside City Limits
	anyle show	10a. Stete 10b. County		y, Town of Location				100.	1 ☐ Yes 2 ☑ No
	vith the Ma nor 28s-f s be norther Director	Maryland Baltimo	re	Rossvi					
	it is	10e. Street end Number		10f. Z	p Code		10g. Citizen of	What Country	7
	ath v	8800 Ridge Road			21237		United		
	ifter death v	11. Marital Stetus	 Was Decedent Ever in U, Armed Forces? 	,S. 13. Was Dec If Yes, sp	edent of Hispenic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.))- 14. Ha Bla	ce - American ack, White, etc	
20	y Fr	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes	2 No Specify:		Specia	^{γ∵} Whi	i te
8	within 72 hours after death with the Maryland ena. The Manical Evandore must be notified at the Madical Evandore must be notified at ompleted by Funeral Director	3 Widowed 4 □ Divorced	Year or Dates:	10- Davidson 11-	t O was time		16h Kind of B	Business/Indus	
5	ed within 72 ho ygiena. Per than "naturi nt, me Medical tt, me Medical	15. Decedent's Edu (Specify only highest great		16e. Decedent's Us (Give kind of w	ork done during most of w use retired)	vorking	TOD. KING OF E	usiness/indus	itty
12	within	Elementary/Secondary (0-12)	College (1-4or 5+)		ne Maker		Dum	Home	
7	Hygie III.	12 years 17. Fether's Neme (First, Middle, Last)		110		ame (First, Middle			
an	ntal Hed off		חסשח			Maria	_	,	
Maryland 21215-0020	s marked other t amarked other t numetic event, ID To Be Co	19a. Informant's Name/Relationship (7)		19h Mailing Addres	ss (Street and Number or I			. Stete. Zip Co	ode)
₹	d 2 s th en 7 is i								
d)	1 end Health ern 27 other tu	Vito Migliaccio / 20a. Method of Disposition	20b. P	lace of Disposition (N	utty Fill Av	Date	20c. Location	- City or Town	. 1234 , State
ŏ	or o	1 ☐ Burial 2√☐ Cremation 3 ☐ F	Removal from State	emetery, cremetory or		0.40.04	-		7 (
ij	t. Pe tmar tant: njury	4 Donation 5 Other (Specify)		lltop Serv	nd Address of Facility	8-18-04	lowsor	n, Mary	land
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantel Hygiens. Important: If the IZ1s merked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Marient Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licens	99				_		ork Road
	401.00	Tatut 11/as	Tlemise		Towson Fune		•		, MD 21204
	Physician /Medical Examiner	23a. Part1. Enter the disease, or comp shock, or heart faiture. List only o Immediate Cause (Final disease or condition resulting in deeth)	a Myocard	Lial I				Or	terval Between nset and Death
Box 68760,	v requires that the death certificets be executed been signed by the attending physician and should be datached for usa as the buriel-transit leted by Physician/Medical Examiner	Sequentially tist conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	Due to (o	ras e consequence of	:	rs(
Ď	atte d for	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlying	ceuse given in Part I	23b Did	tobacco use co	entribute to th	e cause of death?
P. 0.	the d	Part II. Other significant conditions con	Mindraling to death but not rest	aiting in the andenying	couse given in rate.	1 🗆	1		oly 4 □ Unknown
υ.	as that igned b be date by Pl	thy pertent	\sim			-	100 254.10		.,
Records,	The law requires that the sate has been signed by th page 2 should be datache.	\'					an autopsy	24b. Were	autopsy findings ble prior to
Ö	The law requirate has been single 2 should					репо	med?		letion of cause
æ	has ge 2					100	re Vine		es 2□No
7	Ficate 7. Pa	25. Was case referred to medical			OS Place of D	eath (Check only o	100 40	1	
₹	Physician: rthis certific iral director.	examiner? -	Hospital:	ER/Outpatient 3 [Other:	Home 5 Resid		nor (Consile)	-
ō	Physic this caral dire	27. Manner of Deeth	28e. Date of Injury	28b. Time of	28c. Injury at		now injury occur		
ם	After fund	1 Naturet 5 Pending investigation	(Month, Dey Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No				
<u>s</u>	Attending or death. ector: After by the fune tiffication	3 Suicide 6 □ Could not be	28e. Plece of Injury - At ho	ome, farm, street, facto	rv. office	28f. Location (Street and Numi	ber or Rural R	oute Number,
Division of Vital	tal or Attending P rs after death. al Director: After t led in by the funara Certification;	4 ☐ Homicide determined	building, etc. (Specify			City or To	vn, Stete)		
_	pital ours a filled	29a. Certifier Certifying Phys	sician: To the best of my know	wiedae, deeth occurre	at the time, date and pla	ce, and due to the	cause(s) and m	anner es state	ed.
	he Hospi in 24 hou he Funer pletely fill edical	(Check only 2 Medical Exami	ner: On the basis of examiner and manner steted.	tion end/or investigation	n, in my opinion, death oc	curred at the time,	date and place,	end due to the	a cause(s)
	To the Hospital or Attending Physician: The law within 24 buours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 medical Certification: To Be Comp	29b. Signature end title of certifier		2	c. License number		29d. Date signe	id (Month, Da)	y, Year)
	F≯Fö	DOA 0	0 - 1		NELOJO	a	8/16	Inv	
	,0	- I'llia	ampleted source of death ("	23e) (Tuno Brint)	SULT		مربو		21061
	2		in Tays	1 230) (Type, Print)	od load	Stous	D Colo	n Bi	yn we tan
		31. Dete filed (Month, Day, Year)	32. Registrar's Signa		- Cour	مر قال	(4)	, Cu	עש, אנו
	State	ALIC 1 6 2004	Grange B	book					

DHMH 16 Rev 6/95

				For State Registrar	State of Marylan	d / Depa	artmei		alth and N	Mental Hyg	giene Reg. No	2001	256	52
	D	Physicia	an	1. Decedent's Name (First, Middle, Last)				_		2. Date of Dea Month		¹ 2,2004	3. Time of	
		/Medic	97			ller	41 01	T.V	- d Doodh	Augus	7	2,2004 County of Death	1:	00₽m
		Examin	er	4a. Facility Name (If not institution, give s			4b. City	Town, or Lo	cation of Death			Baltimor	-0	
	8	Funeral	3	Stella MAris H 5. Social Security Number 6. Sex		last birthday)		er 1 Year If	Under 24 Hrs.	8. Date of Birth				or Foreign
	Q _{EC}	Director			M 2♥F 82	Yrs.	Months	Days	lours Min.	Sept.	22,	192 <mark>1 Ma</mark>	rylan	d
		Marylan	ctor	MD 10b. County Baltim		ty, Town or Lo		ssex				1	1 Tyes	ity Limits 2 ☑ No
		with the	Director	10e. Street and Number 317 S. Taylor	7		10f. Z	ip Code 2122	1		_	itizen of What Coul JSA	ntry?	
		ns 234	erai		2. Was Decedent Ever in U	S. 13.	Was Dece			ecrfy Yes or No-		14. Race - Americ	can Indian,	
p.m.	396	within 72 hours after death with the Maryland ans than "natural", or items 23s or 28s-f show is Medical Examinst natal by molified at	by Funerai	1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, spo 1 ☐ Yes		Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		Black, White, Specify hit		
00:	5-0036	n 72 hou "natura colcal E	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	edent's Usi	ual Occupatio	n ng most of wor	king	16b. F	Kind of Business/In	dustry	
<u>:</u> :	121	d within plene. Ir than	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+)		<i>во мот</i> e mak				C	wn home	2	
4	d 2	H Hyge	BeC	17. Father's Name (First, Middle, Last)						ne (First, Middle,	Maider	n Surname)		
2004	ylaı	D 9 2 0	To	Andrew Strzego						Drodz				
2,	Maryland	12 s h ar 7 is trau		19a. Informant's Name/Relationship (Ty) Janet Fewster /	•							or Town, State, Zip Ce MD 21		
1		s 1 au f Hea item otha		20a. Method of Disposition	20b. F	Place of Disponentery, cre	osition (Na	ame of other place)		Date		ocation - City or To		
AUGUST	imo	nit. Pages artment of ortant: If II injury or o		1 分Burial 2 ☐ Cremation 3 ☐ R. '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Sac	credHe	eart	ofJes	us 8/1	6/04	Bal	timore.	MD	
AUG	Baltimore,	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service License	onnelle	1	300	Mace	Ave	Baltim	ore	neralHor		ssex
				23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the dead e cause on each line.	Do not en	nter the mo	ode of dying, s	uch as cardiac	or respiratory arr	rest,		Approximation interval Better Onset and	tween
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	LUNG CANCER									
	1	Examiner			Due to (or as a consec	quence or):								
	*	p #	iner	Sequentially list conditions, if any leading to immunity cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):								
1	60,	be executed sician and burial-transit	I Examiner	that inflated events resulting in death) Last	Due to (or as a consec	quence of):								
1	687	0 2 0	edical											
	. Box	The law requires that the death certificat, tie has been signed by the attending phy page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown	3c. If yes, outcome of pregn. 1□Live birth 2□Feta 4□Pregnant at time of c 9□Unknown	al death 3	□Ectopic □ Other (s	pregnancy specify)				23d. Date of delive Month		Year
	P.0	that the de ed by the detached		Part II. Other significant conditions cor	itributing to death but not res	sulting in the o	underlying	cause given i	n Part I.	23e. Did to	bacco	use contribute to t	he cause of	death?
ER	rds,	w requires that been signed should be det	ed by							1 🗆 Y	es 2	2 □ No 3 □ Prot	oabiy 4 🛣	Unknown
MILLER	Records	law re as bee 2 sho	Completed							24a. Was a	sy	24b. Were auto	psy findings	available
			Com								rmed? 2 ∑ No	death?	2□ No	
IAN	Vital	Physician: r this certifica ral director, I	Be	25. Was case referred to medical examiner?	lospital:	1500		Other		th (Check only or				
VIVIAN	of	× 0 0	1: To	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury at	4 ☐ Nursing H	ome 5 ☐ Resid 28d. Describe h		6 Other (Special Control occurred)	y) HOSI	,ICE
	ion	Attending r death. sctor: Alteby the fune	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes	2 □ No					
	Division	af or Atte s after de al Diracto ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, st	treet, facto	ory, office		28f. Location (S City or Tow		nd Number or Run (e)	al Route Nun	nber,
		To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurre	ed at the time, on, in my opini	date and place on, death occu	, and due to the or rred at the time, o	ause(s date ar	s) and manner as s nd place, and due t	stated. o the cause(s)
		To the within 2 To the complet	Σ	29b. Signature and title of certifier			2	9c. License n			29d. Da	ate signed (Month,	Day, Year)	
		h		1/2		- 02 \ 7	B	リリ	3725			0/10	109	
				DR. TARIO MAHMO				RD	TTMONTI	M, MD 21	noa	ı		
	É		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign			astal	LIVILU	<u> </u>	<u></u>			
		Regist	rar	511C 4 £ 200/	17 marana	27	110	2460						

DHMH 17 Rev 1/2001

EONARD BOBBY MCKNIGHT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item # 18, per, FH, 6835, 9/23/04 TT

State of Maryland / Department of Health and Mental Hygiene 4-5067 1 - For State Registrer Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day LEONARD **Physician** 5, 2004 3:39a AUGUST MCKNIGHT BOBBY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** BALTIMORE SOUTHBOUND ROUTE 295 at ROUTE 895 Battimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F 16 Yrs. 218-25-5651 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 27 Is marked other than "natural", or Items 23a or 28a-f show traumatic avant, It a Modical Examiner must be mailthed at 1 Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10e. Street and Number 21229 USA =lowerton Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 Vo If Yes, Give Year or Dates: 1 ☐ Yes 2 No 1 Never Married 2 Married Specify: Brack Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Studen Elementary/Secondary (0-12) 1040 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sharl Dorine Wilson and Mental F B. McKinta ht, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Legal 19a. Informant's Name/Relationship (Type, Print) Balthore MD 21229 4314 Flowenten Road Health itam 27 | Dova Wilson/grandmot othar 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or off 1 Daurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Andress of Facility
709 TCSSNer 21. Signature of Funeral Service Lice NO EVER TERS Approximate 23a. Pant Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 14 **Physician** /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an autopsy performed? 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 XYes 2 □ No Certification: To 28a. Date of Injury (Month, Pay Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 5 Pending investigation 1 Natural 340A 1 Yes death. 2 Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or City or Town, State) hours after deat 6 ☐ Could not be 7 Suicice 4 ☐ Homicide Suicide 28f ģ determined vollwa 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funeral I 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 5, 2004 AUGUST OCME rus Medal 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HEDOURE MIK 32. Registrar's Signature 31. Date filed (Month, Day, Year)

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State Registrar

AUG 1 6 2004

		,	1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			iene	25651
п	Physici	an	1. Decedent's Name (First, Middle,		1 = D 1 = 1		_	2. Date of Dear	Day Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution,		LEBROC	1	r Location of Deat	AUGUST	9 2004	
	Examir	ier	655 LONG 1	JODD CT	-	15. City, 10WH, 01	LAN A	ı	4c. County of De	
	Funeral		5. Social Security Number unk	6. Sex 7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birth		irthplace (State or Foreign Country) UNK
	Director			1 M 2□F	70 Yrs.	Months Days	Hours Min.	9-15	33	Lountry) UTIK
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary -1 sho	ţ	MD Harfo	ord	Edgew	ood				1 ☐ Yes 2√ No
	72 hours after death with the Maryland haturel', or Itams 23a or 28s-f show citeal Examiner must be natified at	Funeral Director	10e. Street and Number			10f. Zip Code		unk 1	0g. Citizen of What (Country?
	238 C	a	655 Longwood	Court				dik	USA	
	ar dea	nei	11. Marital Status	Armed Forces?	unk	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 No If Yes, Give Year or Dates:	dik	1 ☐ Yes 2 ☑ No	Specify:		Specify:	black
5-0036	P hou	edit	15. Decedent'		16a, Dece	edent's Usual Occupa	ation	unk	16b. Kind of Busines	
215	within 72 ene. than "na	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+	(Give	kind of work done of DO NOT use retired	during most of wor	king		s/industry unk
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nd	ba fill tal Hy od oth	Be	17. Father's Name (First, Middle, L	ast)		unk	18. Mother's Nar	ne (First, Middle, M	Maiden Sumame)	unk
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artinent of Health and Mental Hygiene. ortants if Item 27 is marked other than "natural", or Itams 23a or 28a-f show injury or other treumetic event, the Madical Examinet must be notified at a.	ပ	19a. Informant's Name/Relationsh	in (Time Print)	10h Mail	in a Address (Otrost				- 1
Ma	ith an		Diane Lawder/Ha		19b. Maii	ing Address (Street a	ana Number or Hu	rai Houte Number	, City or Town, State,	Zip Code) unk
<u>a</u> ,	parmit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or othar tr. once.		20a. Method of Disposition	TIOIU CO FI	20b. Place of Disp	osition (Name of	-1	Date	20c. Location - City o	r Town, State
Baltimore,	Pages nent of i int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp	ecify) in state	cemetery, cre	matory or other plac	θ)			
alti	parmit. Pag Department Important: any injury conce.		21. Signature of Funeral Service I	icensee	lather &	2. Name and Addres	s of Facility	1 (55 11	Baltimore	
m	20 = 20		Monunt	1/100	B	altimore,	MD 212	01 633 W.	Baltimore	Street
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	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_aM	jocardi	ol in	Paretu	m		Onset and Death
	/Medical Examiner		rosaming in doduity	Due to (or as	consequence of):	p. 1.	<i>b</i>	. 0	direne	
	NE DE	ē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):	The Con	olions	Cular	alkone	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
o.	that the do	yslo	1	9 Unknown	me or death - 5t	_ Other (specify)				
σ.	uires that signad b d be deta	by P	Part II. Other significant condition	s contributing to death but	not resulting in the u	inderlying cause give	an in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
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of Vital Records,	y S	2	1 X Yes 2 □ No 27. Manner of Death		2 ER/Outpatie		4 Nursing H		nce 6 Other (Spe	ecify)
	ding h. After funer	tlon	1 Natural 5 Pending		Year) 280. Time o	Work	rat (? (es 2 ☐ No	28d. Describe ho	w injury occurred	3
Division	I or Attending after death. Director: After I in by the funer	fica	3 Suicide 6 Could no	ot be 28e. Place of Injury	y - At home, farm, st		.03 2	28f. Location (Str	reet and Number or R	lural Route Number.
ē	al or all or all or all or bire	Certification:	4 Homicide	building, etc.	(Specify)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town		
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of xaminer: On the basis of e	xamination and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within To the Comp	ž	29b. Signature and title of certifier	1111		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
•			Benack &	Kolm MD.	DIE	DCO1	4206		lugist	10,2004
			30 Name and address of person w	no completed cause of dea	- ^ -	Print)	0.4. 4.		The	
			31 Date filed (Month Day Vocal	YUKNA MI Registrar	D. DME /	DIE HOLAL	WRD AVE	BALIC	Md Z	1222
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 6 2	1004 Hegistrar	s Signature	all .				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13,2004AUGUST **Physician** MENTE MARIE LOUISE 4:27AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□√F 217-52-3004 57 1946 Washington,DC Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "neturel; or Items 23a or 28e-f show any injury or other fraumatic event, The Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits MD Howard Clarksville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 12702 Route 108 21029 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Benefits Coordinator Human Resources 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louis Joseph Naecker Marie Thelma Beall ပ 19a. Informant's Name/Relationship (Type, Print) (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12702 Route 108 Clarksville, MD 21029 Mrs. Marie Thelma Naecker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State George Washington Cem. 8/16/04 Hyattsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & Sykesville, MD 21784 & CHAPEL, P.A. (Box 195) 34 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) B seast Cancers to the LIVER METASTATIC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner g physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Yo Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4 le Paruxent Pky Columbius MOZOU 3*850*9 of death (Item 23a) (Type, Print) 30. Name and address of person 10 1106 Nicholik 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 6 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health a

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13	Sec. 4	100	100	6
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3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician
/Medical
Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland neturel', or Items 23a or 28a-f show Itsul Examinar must be notified at

Provenza, Vincent

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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To B	Vincent Prove	nza			Cimino	ion comano,	
	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mailing Address (Stree			ty or Town State	Zin Codo
	Mrs. Lucia S. Pr	ovenza (Wife)	4000 N. Char				. Md. 2121
	20a. Method of Disposition		Place of Disposition (Name of	Date	20c.	Location - City of	r Town, State
	1 ☐ Burial 2 ☐ Cremation : 1 ☐ Donation 5 € Other (Specific		cemetery, crematory or other pla raine Park Mausole		Mor	odlawn Ma	aryland
İ	21. Signature Aug ral Service Li		22. Name and Addr		NOC	Julawii i'k	21204
	Michael & C	leak in	Ruck Towson	Funeral Home, I		York Road	24-20-20-20-00-00-00-00-00-00-00-00-00-00-
	23a. Part . Enter the disease, or c shock, or heart failure. List of	omplications that caused the dea	th. Do not enter the mode of dy	ing, such as cardiac or res	piratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	th (. c)	te maeb				Onset and Death
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	resulting in death) Last	Due to (or as a consec	quence of):				
riiysiciaii/medical		d					
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2 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 Live birth 2 Feta	ancy II death 3 □Ectopic pregnanc			23d. Date of de	livery
2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		y		Month	Day Year
	9 🗆 Unknown	9L Unknown					
Dy L	Part II. Other significant condition	s contributing to death but not res	sulting in the underlying cause given	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
					1 🗌 Yes	2 No 3 P	robabiy 4 🗆 Unkno
combiered					24a. Was an	24b. Were at	utopsy findings availa
5					autopsy performed?	prior to death?	completion of cause
	25. Was case referred to medical				Yes 2	No 1 ☐ Yes	2 □ No
3	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Innation 2	ER/Outpatient 3 DOA Oth	26. Place of Death (Che		C 170st /0	T. In Section 1
F	27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Injui	ry at 28d. [Describe how in	iury occurred	city) MOSPILE
	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year)		rk? Yes 2∐No	•	, , , , , , , , , , , , , , , , , , , ,	
	3 Suicide 6 Could no	be as Bt (1)	ome, farm, street, factory, office		ocation (Street :	and Number or Ri	ıral Route Number.
1	4 Homicide determin	building, etc. (Specil	(y)	2	ity or Town, Sta	ite)	na riodio Nambor,
	29a. Certifier 1 Certifying	Physician: To the best of my kno	wledge, death occurred at the til	me date and place, and d	ue to the cause	(s) and manner as	stated
Medical	(Check only 2 Medical Ex	aminer: On the basis of examina and manner stated.	tion and/or investigation, in my o	ppinion, death occurred at	the time, date a	nd place, and due	to the cause(s)
1	29b. Signature and title of certifier	^	29c. Licens	se number	29d. D	ate signed (Monti	h, Day, Year)
	> 54V //~	7	1 2	108411		8/12/.	2 - 2 - 2 - 2
-	30 Name and address of assess wh	on an eleted source of death /live	2	10037		9/ /	2004
	30. Name and address of person wh		ST Oc. 1	1 Bald:		1 71-	2 67 2
	31. Date filed (Month, Day Year)	Sebera 301 Registrar's Signa	duras Paul P	L Baltim	ore m	ra cla	0<
e r	AUG 1 6 200	4 Denewar	A Societal				

1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year D. Vincent Provenza 379 G M augi 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Baltimore Stella Maris Hospice at Mercy Med. n/a | Months | Days | Hours | Min. | November 27, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland 1 M 2 □ F 220-07-4223 86 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland n/a/ Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4000 N. Charles Street Unit 1001 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 X No þ Specify: White 3 Widowed 4 Divorced ted 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Education den Surname) ty or Town, State, Zip Code) 01 Balto. Md. 21218 Location - City or Town, State odlawn Mary land 21204 York Road Towson, Md. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year

DHMH 17 Rev 1/2001

Purviance, Melvin

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			For 1 - State Registrer	State of Ma	-	artment of Health ar		ene 1,2004 25657
	Physici	an	1. Decedent's Name (First, Middle	,	D		2. Date of Death Month	Day Year 7:26A M
	/Medic Examin		Mels 4a. Facility Name (If not institution		D. F	Purviance 4b. City, Town, or Location of I	PluguST /	4c. County of Death
			Stella Maris	- Mercy		Baltimore	•	NA
١	Funeral Director		5. Social Security Number 218-10-7631 Usual Residence of Decedent	1 % 1M 2□ E	e (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day, Y 1-28-21	(ear) 9. Birthplace (State or Foreign Country) Md.
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation		10d. Inside City Limits
	Many B-f sh	tor	Md.	NA	Balt	imore		X ☐Yes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Code	10g	. Citizen of What Country?
	s 23s		2110 Orleans			21231		USA
_	ter de item	Funerai	11. Marital Status 1 □ Never Married 25€ Married	12. Was Decedent E Armed Forces? ried 12 Yes 2 1 N	ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
2-003e	inisal inion	Š	3 ☐ Widowed 4 ☐ Divorced	TYPE Give		1 ☐ Yes 21 No Specify:		Specify: Black
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20	filed Hygie Sther	ပိ	11th grade 17. Father's Name (First, Middle,	Last)			Name (First, Middle, Ma	
<u>a</u>	lid be fental rked c	ToB	Edward	Direct	iance	Maria	an	Gibson
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exaciliar most be redifficed at once.		19a. Informant's Name/Relations			ng Address (Street and Number of		
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	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 2 ☐ Cremation			natory or other place)		C. Location - City or Town, State
altimor	artmer artmer ortant injury		* 4 ☑ Donation 5 ☐ Other (S 21. ign ure of Funeral Service			2. Name and Address of Facility		Baltimore, Md. timore, Md. 21202
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Н			23a. Fart1. Enter the disease, or	complications that caused only one cause on each lin	the death. Do not ent	er the mode of dying, such as car		
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	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):			
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oo,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):			
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	ling P	ion:	27. Manner of Death 1 ■ Natural 5 ■ Pendin		y Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	njury occurred
20	death death ctor: y the	ficat	2 Accident investig	not be 280 Blace of Injur	ry - At home, farm, stre	M 1 Yes 2 No	28f. Location (Stree	t and Number or Rural Route Number.
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier Certifyin (Check only one) Certifyin	g Physician: To the best of Examiner: On the basis of and manner stat	examination and/or inv	occurred at the time, date and pivestigation, in my opinion, death o	lace, and due to the cause occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Fo the within Fo the comple	Med	29b. Signature and title of certifier			29c. License number		Date signed (Month, Day, Year)
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	111		30. Name address of person	Diel	eath (Item 23a) (Type,		PI Balt	imore 21202
	Stat Registra		31. Date filed (Month, Day, Year) AUG 1 6 20		r's Signature	parte		

04-5047 B.K.S NOCK

PAUL		1- State of Maryland / State of Maryland / Per Registrar	Department of Health at The 1834 8/17/04 Certificate of Death	nd Mental Hygie	ene
Physicia /Medic	an	1. Decedent's Name (First, Middle, Last) Fnock Paul		2 Date of Death	Day 2004 Year 0450 A
Examin		4a. Facility Name (If not institution, give street and number) I_95 NORTHBOUND ON BRIDGE	4b. City, Town, or Location of N/A		4c. County of Death CECIL
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 183–70–7526	Yrs. If Under 1 Year If Under 2 Hours Hours Hours	Min. 8. Date of Birth (Month, Day,) Jan • 10,	(ear) 1972 9. Birthplace (State or For Country) Haiti
Maryland -f show fied at	tor		wn or Location erset		10d. Inside City Li
with the Garage or 28s	i Director	10e. Street and Number 131 Hillcrest Ave.	10f. Zip Code 08873	100	g. Citizen of What Country? USA
72 hours after death with the Maryland neture!; or items 23e or 28s-f show deal Examination matter and iffed at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Ses 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ► No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
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und 2 sho alth and h 27 is ma er frsume	ľ	1 1 21 1 1	b. Mailing Address (Street and Number Radnor Court Will		City or Town, State, Zip Code) 08046
permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked any injury or other traumette events.		1 Durial 2 Cremation Removal from State 4 Donation 5 Other (Specify)	iew Memorial Park		innaminson, NJ
permit. Departi		21. Signature of Eunarat Service Licensee Victor P. Doda, 23a. Part1. Enter the disease, or complications that baused the death. Do shock, or heart failure. List only one cause or each line.	Charles L. Stevens 1501 East Fort Aven	ue Baltimore 1	4D 21230
Prysicial Items of the present of the present of the present of the price of the pr	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause; (of sease of it for y that initiated events resulting in death) Last a. Contact Gunsh Due to (or as a consequence cause. Enter Underlying Cause; (of sease of it for y that initiated events resulting in death) Last Due to (or as a consequence d.	e of):		
I the death certificate by the attending phys lached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
- g 2 9	ρ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		cco use contribute to the cause of death
e law has b	Completed			24a. Was an autopsy performe	
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Medical Certification: To Be C	1 Natural 5 Pending Formath, Day Year) Fo	Outpatient 3 DOA Other: 4 Nursell Nurs	of Death (Check only one) sing Home 5 Resident 28d. Describe how Decedent 28f. Location (Strecity or Town), Cecil Cou	Shot Self et and North Property, Md se(s) and manner as stated.
To To	i .				11 2001
To with To		30. Name and address of person who completed cause of death (Item 23a		imore Marvi	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year PARRETT CECIL LEON 1135 AM 08 07 /Medical 2004 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE HAVRE DE GRACE, MD HARFORD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X**] M 2□ F Months Days Hours Min. Director 219-34-4231 66 11/02/1937 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ul Hygiene. I other than "netural", or tlems 23a or 28e-f show went, tre Medical Exercit at trust be rollfied at 10d. Inside City Limits 1 X Yes 2 □ No MD Harford Havre de Grace Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 Revolution Street, Rear 21078 Pages 1 and 2 should be filed within 72 hours after death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Plumber Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental It 27 Is marked of treumatic ever Elmer L. Parrett, Sr. Elizabeth R. Laird 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Barbara Parrett- Wife 730 Revolution St., Rear, Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. 08/09/04 West Chester, PA 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. waine 123 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arlen Physician . Oronamy 5 Months /Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death P.O. I 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hyper leuhon 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Attending Physicien: : After this certification Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funerel Direct completely filled in by filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) man D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REVOLUTION ST HAVRE DE GRACE 31. Date filed (Month, Day Year) AUG 1 6 2004 32. Registrar's Signature State Registrar

			For State Registrar	State of	Marylar	•	artment <i>rtificate</i>			d Mental Hy	giene	001	25660
			Decedent's Name (First, Middle	, Last)						2. Date of De	ath		3. Time of Death
	Physici		JOSEPH	A.		ΡΔ. Τ	TIS	SR.		AUGUST	Day	Year 2004	3:10 p ^M
	/Medic Examin		4a. Facility Name (If not institution		ber)	1110	4b. City, T					County of Death	13:10 p
1	LAdiiii	C1	FUTURE CARE				BZ	LTI	MORE			N/A	
	Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under 1	Year If	Under 24		th		place (State or Foreign ntry)
	Director		218-28-6669	X M 2□F	71	Yrs.	Months	Days F	Hours !	Min. DEC.	ı <i>y, Үөаг)</i> 1,1 9	32 MAR	YLAND
			Usual Residence of Decedent										
	show		10a. State 10b. County		10c. Cr	ty, Town or Lo	cation						10d. Inside City Limits
	B-f.s	ç	MD. N/	A		BALTI	MORE						1X Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip 0	ode			10g. Citiz	zen of What Cou	ntry?
	11 wi	a	211 S. ROBI	NSON STR	EET		21	224				U.S.A.	
	dea ens	ner	11. Marital Status	12. Was Deced	dent Ever in U	I.S. 13.	Was Decede	nt of Hispa	nic Origin Mexican, P	? (Specify Yes or No uerto Rican, etc.)) - 1	14. Race - Ameri Black, White,	can Indian,
9	ours after death with the Maryla rel', or Items 23s or 28s-f shov Examiner must be notified at		1 Never Married 2 Marr		2X No		1 □ Yes 💥		Specify:	,		Cassifu	
21215-0036	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show dical Examinat must be redified at	d by	3 X Widowed 4 ☐ Divorced	Year or Da		,						MH	ITE
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Maryland	ges 1 and 2 should be filed within 72 hc t of Health and Mental Hygiene. If item 27 Is marked other than "natur or other traumatic event, Its Madical		19a. Informant's Name/Relations! THERESA PAJTI		FD					REET, BAI			
-	1 and Health		20a. Method of Disposition	5/ DAUGIII		Place of Dispo			11 21	Date DAI		cation - City or To	
ō	ges Total		1 Deurial 2 □ Cremation		tate	cemetery, crer	natory or oth	er place)				•	
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Baltimore,	permit. Pages 1 and 2: Department of Health as Importent: If item 27 is any injury or other trauging.		21. Signature of Funeral Service	Licensee		L	TTTY	& ZE	TEE	INC. FU	JNER	AL HOM	E
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_	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	00 01 00 (0	as a conseq	juerice or).						ļ	
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Division of Vital Records,	after Dira	Certification:	4 ☐ Homicide determi	building	g, etc. (Specif	ý)	,,,,			City or Tox	vn, State)		
_	spite ours nerel filled		29a. Certifier 1 Certifyin	g Physicien: To the b	est of my kno	wledge, death	occurred at	the time, d	date and pl	ace, and due to the	cause(s) a	and manner as si	ated.
	24 h 24 h e Fur etely	edicai	(Check only 2 Medicel I	eminer: On the bas and manne	sis of examina	ition and/or inv	estigation, ir	my opinio	on, death o	ccurred at the time,	date and p	place, and due to	the cause(s)
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1)		30. Name and address of person	who completed cause	of death (Item	n 23a) (Type.							
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Physici	an	1. Decedent's Nam	y G. Phi	-						Month	D	ay	Year	3. Time of Dea
/Medic				ve street and number	9r)	4b City	Town o	r Location o	of Death	Aug.		COUNTY	of Death	40,10
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Funeral Director		5. Social Security N 212-07-0		Sex 7.7 1 ☐ M 2 ☐ XF	Age (In yrs. last bi	rthday) If Under Yrs. Months	1 Year Days	If Under 2 Hours	Min.	8. Date of B (Month, D Jan.	irth ay Yea 18, 1		9. Birth	place (State or For ntry) ryland
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			Decedent's Name (First, Middle, La.	st)		2. Date of Death	, 600	3. Time of Death-					
	Physici		DONAL	D RI	ELD			AUG.	Day Ye				
and the same	/Medic Examir		4a. Facility Name (If not institution, give	7		4b. City, Town, or	Location of Death	,	4c. County of D				
1	LXdiiii		Brightwood Center			Luthervil	le		Baltimo				
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)			
	Director		215-10-3714	OXM 2□F	86 Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 18.	4047 4	Country)			
	₽		Usual Residence of Decedent					17.49. 10.	+2+7	ZATIOUII			
	how.		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits			
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	or 21	- E	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	t Country?			
	23a	Funeral Director	205 E. Joppa Road	Unit 150	1	21286			USA				
	e E	ne l	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc.			
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21215-0036	within 72 hours efter death with the Maryland ene. than "natural", or Itams 23e or 28e-f ahow has Madigal Examinar mast be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					Spoony. W				
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12	the second	ם	Elementary/Secondary (0-12)	College (1-4or 5-	H) !	officer				•			
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au	od o	Be .	Sinai George Brown	า			Mildred	Flemmi					
Maryland	s 1 and 2 should be filed within 72 hours efter death with the Maryler of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other traumatic avant, the Medical Examinar must be notified at	၉	19a. Informant's Name/Relationship		19h Mailir	ng Address (Street a				o Zin Codol			
B	d 2 s th an 7 la trau		Timothy A. Reid	,									
	1 and 1 Health am 27 sther tr		20a. Method of Disposition	/ son	20b Place of Dispo	Rejester sition (Name of matory or other place		oate 2	Oc. Location - City	or Town. State			
ō			1 ☑ Burial 2 ☐ Cremation 3 ☐			/14/04 Baltimore, MD							
Baltimore,	rtmerit		* 4 □ Donation 5 □ Other (Specify 21. Signature of Furieral Service Licen		Parkwood	2. Name and Address	1	704 00	artimore,	, ויוט			
Ba	permit. Peges 1 a Depertment of Hea Important: If Itam any Injury or oths once.		21. Signature of Control Service Licen	7)					1050 Yor				
		\vdash	22a Part 1 Enter the disease or com-	disations that caused		ck Towson			Towson,	MD 21204 Approximate			
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	1						Interval Between Onset and Death			
>	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a.	EBROV	ASCUL,	4R f	ACCIDE	アイ	NONTHS			
1	/Medical Examiner		f		consequence of):			USARS					
L		_	Sequentially list conditions,	0.	consequence of):)		YEARS					
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ğ	death certific ettending pi d for use es t	Physician/Me	in the past 12 months?	1 Live birth 2 4 Pregnant at t		Ectopic pregnancy Other (specify)			Month	Day Year			
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	res thet Igned b be deta		Part II. Other significant conditions of	ontributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute	to the cause of death?			
of Vital Records,	uires n sign	d by						1 ☐ Yes	2 🗆 No 3 🗆	Probably & Unknown			
00	w requ	Completed						24a. Was an	24b. Were	autopsy findings available			
Re	The lav ete has page 2:	Ę,						autopsy performe	prior t ed? death	to completion of cause of ?			
tal	iclan: Th certificete rector, pag	Ü	25. Was case referred to medical				26 Place of Death	1 Yes 2 (Check only one)		es 2 No			
5	Physician: this certifice ral director, p	70 B	examiner?	Hospital: 1 ☐ Inpatien	t 2 ER/Outpatien	Othor	-	me 5 Residen		noniki)			
ō	Ph)		27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe how		рвспу)			
Division	th. TA	읉	1-☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		es 2 No						
VIS.	Attar r des actor by th	<u></u>	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Inius	y - At home, farm, stre	eet, factory, office				Rural Route Number,			
ă	a afte	Certification;	4 🗆 Homicide	building, etc.	(Зреспу)			City or Town,	State)				
	To the Hospitel or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	sician: To the best of	my knowledge, death	occurred at the time	e, date and place,	and due to the cau	se(s) and manner	as stated.			
	ne Ho	Medical	(Check only 2 Medicat Examone)	iner: On the basis of and manner stat	examination and/or invest.	estigation, in my opi	nion, death occurre	ed at the time, date	e and place, and d	ue to the cause(s)			
	withii To th	ž	29b. Signature and title of certifier	0		29c. License	number	290	I. Date signed (Mo	onth, Day, Year)			
	1		> Sust	MD		Doo	5 3150	AL	16057	1300 2004			
	211		30. Name and address of person who o	ompleted cause of de	ath (Item 23a) (Type,	Print)	7150						
_			Sh A KUNN		PTA PO	BOX 6303	B, ECLI	677 CI	77 210	13 th 2004			
	Sta	te	31. Date filed (Month, Day, Year)	4 32. Registrar	's Signature	south!	/						
	Registr	ar	AUG 1 6 2004	Sanger	10 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 2004 7:50 pm Mary Emogene Reinhart 13 /Medical August 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Manor Care Rossville Rossville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 T Yrs. Director 222-01-2847 86 08/19/1917 Maryland Usual Residence of Decedent the Maryland r 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore BAltimore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ir than "natural", or fleme 23a or the Medical Examinan must be 3930 New Section Rd Rt 21220 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Marned 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No White If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWn Home 12 Homemaker other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be fill Depertment of Health and Mental H Importent: If Item 27 is marked oth any injury or other traumatic even 90s8. Peges 1 and 2 should be nent of Health and Mental Etta Jane Horsey Elmer Shockley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 601 Nollmeyer Rd Balto MD 21220 Tilden Reinhart Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 08/16/04 Baltimore, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave Baltimore, MD 21221 onne 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** orsw. T /Medical Due to (or as a consequence of) **Examiner** Budent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Completed by Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Gunknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete has the autopsy performed? 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ 110 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral to 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 6 2004

MU)

22. Registrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

HASILMI

29c. License number

31464

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician August 5, 2004 Isaac Ruffin 11:02 AMM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□F Months Days Hours Min. unk Yrs. 69 June 8, 577-46-3365 Director Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or then "neturel", or Items 23a or 28a-f show the Medical Examinar must be notified at DC 1 ☐ Yes 2x No Washington Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1428 17th Street NW 20036 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk Hygiene. Colfege (1-4or 5+) unk permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Importent: If item 27 is marked other any injury or other treumatic event, 11nk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Holy Cross Hospital 1500 Forest Glen Road Silver Spring, MD 20910 e of Disposition (Name of Date 20c. Location - City or Town, State 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 M Other (Specify) KONALD S. Wade in state 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** subacute bacterial endocarditis unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physician/Medical ding pl IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Vear 4☐Pregnant at time of death 5 Other (specify) Records, P.O. been signed by the should be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown renal failure hypotension 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 4 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 (Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 2 ER/Outpatient 3 DOA 7 After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Death Certification: 5 Pending 1 Tes 2 No death. investigation 2 Accident Director: 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1th Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and tulk of certifie ompfeted/cause of death (Item 23a) (Type, Print) 30. Name and address of person aslop 32. Registrar's Signature 31. Date filed (Month, Day, Ye State Registrar

			1 - For State Registrar	State of M	laryland .		artment of H rtificate of			giene neg. NG. () () ()	25665				
			1. Decedent's Name (First, Middle, L	ast)				-	2. Date of Dea Month	nth Day Yea	3. Time of Death				
н	Physici /Medio		Willard	Maurice	Rippo	ns			Aug	14 2001					
	Examin		4a. Facility Name (If not institution, ga					r Location of Death		4c. County of De					
				C ALLACTIC	HOSPI			RINGE		DORCHE					
	Funeral			Sex 7. A 1	ge (In yrs. last	! birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. E	Birthplace (State or Foreign Country)				
	Director		216-16-7580 Usual Residence of Decedent	X	81	113.	1		Aug 5,	1923	MD				
	and w		10a. State 10b. County		10c. City, T	own or Lo	ocation				10d. Inside City Limits				
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	1 the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?				
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	deatl	Funeral	11. Marital Status	12. Was Deceden Armed Forces	Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-		merican Indian,				
9	or ite		1 Never Married 2 Married	1 Yes 2 If Yes, Give			1 ☐ Yes 2 ☑ No	Specify:	o moan, etc.)	Specify:	White				
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. dother then *natural; or items 23e or 28e-f show event, the Medical Examinative Indiffed at	d b	3 ₩ Widowed 4 Divorced	Year or Dates:	WWI		123 703 EAT NO			Зреспу.	MILLE				
5	72 h 'natu	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	1	(Give	dent's Usual Occup kind of work done	during most of wor	kin g	16b. Kind of Busines	ss/Industry				
121	within ene.	E E	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire	2)		Wholesa	le Seafood				
2	filed with Hygiene. other ther		17. Father's Name (First, Middle, Las	rt)		Wa	terman	18 Mother's Nam	ne (First Middle	Maiden Sumame)					
anc		Be	Benjamin Ri	,					e Brano						
Maryland	d 2 should be filed within th and Mental Hygiene. 7 is marked other then traumatic event, the M	ဥ	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street			r, City or Town, State	. Zip Code)				
Ma	12 har		Mrs. Pat McCorm							lbyville,D					
ē,	s 1 and 2 of Health itam 27 other tra		20a. Method of Disposition	(20b. Place	e of Dispo	sition (Name of matory or other place		Date	20c. Location - City					
10	0 0 = 5		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Ever	greer	Mem. Ga	rdens 8/1	9/04	Finksburg	, MD				
Baltimore,	- E # F		21. Signature of Funeral Service Lice	-		112	2_Name and Addre	ss of Facility	O CHADE	er DA (D	105)				
B	Depar Impo any ic		> Grand	Sykesville, MD 21784 (410)-795-1400											
	_		23a. Part1. Enter the disease, or co	mplications that cause	d the death. [Approximate				
	Pnysician		Immediate Cause (Final	shock, or heart failure. List only one cause on each line.											
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):												
н	Examiner		O	•											
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	nd rans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c											
Ö,	cate be executed ohysician and the burial-transit	ũ	resulting in death) cast	Due to (or a	s a consequen	ICO 01):									
8760	ate b	dicai	•	d						·					
9	eath certific attending p I for use as I	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy	,				and Date of the	la live a v				
Box	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	ath 3[Ectopic pregnancy Other (specify)	1		23d. Date of d Month	Day Year				
o.	t the de by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it tillie or deati	, 55									
Φ.	g g g		Part II. Other significant conditions	contributing to death	but not resultin	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?				
ds,	uires sign	d by	Hyperfevsio	~					1 🗆 Y	es 2 No 3	Probably 4 Unknown				
202	w requ been shoul	lete	Hiper Lincol.	enim					24a. Was a	ın 24b. Were	autopsy findings available				
of Vital Records,	The lav	Completed	7.7 10.00		-				autops	med? death	o completion of cause of				
ta			25. Was case referred to medical					26. Place of Dea	1 ☐ Yes	2)21√o 1 □ Ye	es 2 250 0				
5	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impat	ient 2□ER	/Outpatier	nt 3 DOA Oth		_	ence 6 □Other (Sp	pecify)				
O			27. Manner of Death	28a. Date of Inj	ury 28	b. Time o		y at		ow injury occurred					
Ö	ttanding F death. ctor: After y the funer.	atio	1 Natural 5 ☐ Pending investigate	on	ay / oa//	iii qui y		Yes 2 □ No							
Division	l or Attano after death Diractor: Jin by the	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 289. Place of it	njury - At home atc. (Specify)	, farm, st	eet, factory, office		28f. Location (St City or Town	treet and Number or i n, State)	Rural Route Number,				
	itelo rs aft al Di	Ce													
	Hosp 4 hou Funal	edical	(Check only 2 Medical Ex	Physicien: To the bes aminer: On the basis	of examination		vestigation, in my o	pinion, death occur	red at the time, d	ate and place, and di	ue to the cause(s)				
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Med	29b. Signature and title of certifier	and manner s	tated.		29c. Licens	e number	2	9d. Date signed (Mo.	nth, Day, Year)				
	T wii		Muller	eler was			1) 2	6388		Que us + 1	4 2004				
1			30. Name and address of person wh	n completed course of	death (Item 22	Ra) (Tunn	Print)		/	ا احدادا	//- /				
þ			30. Name and address of person wh	J FAd	dew	My (Type,	300	cullins	Hust	ock mel	nth, Day, Year) 4,2004 21643				
	Sta		31. Date filed (Month, Day, Year)		gar's Signature	9	4 1								
	Registi	ar	MOG I C	, LUUT			apa	Kel							

				1 - For State Registrar	State of	Maryland /	Department o			giene Reg. No. () () ()	25666
				Decedent's Name (First, Middle)	, Last)				2. Date of De	ath	3. Time of Death
		Physici /Medic		Elmer		A.	Sn	ell	Augus	A 13 SON	
		Examir		4a. Facility Name (If not institution	, give street and numb	er)	4b. City. Tow	n, or Location of Death		4c. County of De	ath
				11 kryland	General	140371	tal >	xst imax 6	(ity	NA	
		Funeral		5. Social Security Number	6. Sex 7. 152 M 2 □ F	Age (In yrs. last b	Yrs. If Under 1/16 Months Da	ear If Under 24 Hrs. Lys Hours Min.	8. Date of Bir (Month, Da		irthplace (State or Foreign Country)
		Director		218-12-3672 Usual Residence of Decedent	21	82	113.		6-10	0-22	Md.
		/land		10a. State 10b. County		10c. City, Tov	vn or Location				10d. Inside City Limits
		Many Perfish	to	Md.	NA		Baltimore				1 X Yes 2 ☐ No
		or 28,	Director	10e. Street and Number			10f. Zip Coo	de		10g. Citizen of What 0	Country?
		23a (al [2 S. Pulaski	Street		212	23		USA	
		r dea	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	13. Was Decedent If Yes, specify (of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - An Black, Wh	
	36	urs atter death with the Marylan al', or Items 23a or 28a-f show Evaniner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	₹ No	1 □ Yes 🛂	No Specify:		Specify:	ما ماد
	5-0036			15. Decedent	Year or Date		. Decedent's Usual Oc	cunation		16b. Kind of Busines	Black
	215	C 2 30	Completed	(Specify only highes Elementary/Secondary (0-12)			(Give kind of work do life. DO NOT use re	ne during most of wor	king		
	212	d with giene pr the	E O	9th grade	College (1-4		Maintanenc	e	I	liberty Gar	dens Apts.
6		be filed within tal Hygiene. Id other then "event, the Me	Be C	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	e (First, Middle	, Maiden Surname)	
The \	Maryland	should be filed within and Mental Hygiene. Is marked othar than aumatic evant, the M	2	Edward		Snell		Sarah		Jackso	n
1)	Jar	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relations	nip (Type, Print)	19	b. Mailing Address (Str	reet and Number or Ru	ral Route Numb	er, City or Town, State,	Zip Code)
U		s 1 and 2 of Health itam 27		Lottie M. Sne	llWife		2 S. Pula of Disposition (Name of	ski St., B	altimore Date	20c. Location - City of	
mec	altimore,	of in		M☐ Burial 2 ☐ Cremation	3 Removal from Sta	ate cemete	ary, crematory or other	place)			
5	Ħ	permit. Pag Department Important: I any injury o		' 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service		Mt. Z	ion Cem. 22. Name and Ad		7–04	Lansdowne	
111	Ba	permit. Page Department Important: If any injury o		21. Signature of Fullerar Service	a lu a					imore, Md. North Ave.	21202
1				23a. Part1. Enter the disease, or	complications that cau	sed the death. Do	March F.				Approximate
_		Dhusisian		shock, or heart failure. List Immediate Cause (Final	C	7.	74 11)			Interval Between Onset and Death
	7	Physician /Medical		disease or condition resulting in death)		as a consequence	Medi Fo	nure			
		Examiner		Over a state the tipe and divine	C.	onary	artery	diseas	e		
	н	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence	of):				
		and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c		-0				
	60,	cate be executed by sician and the burial-transit		rosalting in dodiny East	Due to (or	as a consequence	or):				
(V	8760,	physics the k	Physician/Medical		d						:
	9 x	leath certifica attending plant of for use as t	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco					23d. Date of de	alivery
	Вох	atter d for u	ciar	in the past 12 months?		h 2 Fetal deat it at time of death	n 3 □Ectopic pregna 5 □ Other (specify			Month	Day Year
	P.O.	that the de ed by the a detached f	hys	9 Unknown	9□ Unknow	n					
		The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by P	Part II. Other significant condition	ns contributing to deal	th but not resulting	in the underlying cause	given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
	ıd	w require been sig should b							10	Yes 2□No 3□F	robably 4 Nnknown
	၁၁	e law re has be ge 2 sho	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
	Œ.	The I	mo:						perfo	rmed? death? 2. No 1 □ Ye	s 2 No
	/ita	lysician: Th iis certificate director, pag	Be (25. Was case referred to medical examiner?	1			26. Place of Dea	h (Check only o	on <i>e)</i>	
	of \	Physic this c	2	1 ☐ Yes 2 🛣 No			dipatient 3 DOA			dence 6 Other (Sp	ecify)
	n c	ding Phy h. After thi funeral c	lon	27. Manner of Death 1 2 Natural 5 ☐ Pendin		Day Year) 28b.		njury at Work? 1 □ Yes 2 □ No	28d. Describe I	how injury occurred	
	isio	f or Attendi after death. Diractor: A I in by the fu	icat	2 Accident investig 3 Suicide 6 Could r		Injury - At home f			28f. Location (Street and Number or F	Rural Route Number
	Division of Vital Records,	l or Attendated after death Diractor:	Certification;	4 Homicide determ	building	, etc. (Specify)	arm, street, factory, off		City or Tox		
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.								cause(s) and manner a	
		ha Ho in 24 ha Fu pletel	edical	(Check only 2 Medical one)	and manne		nd/or investigation, in n	ny opinion, death occui	red at the time,	date and place, and du	e to the cause(s)
		To t To t	Σ	29b. Signature and title of certified			29c. Lic	ense number		29d. Date signed (Mor	th Day, Year)
		^		POLIF	> M.D.		- 6	347 4 a	4	8/11	1018
		3		30. Name and address of person	who completed cause	of death (Item 23a)	(Type, Print)	4 0	1.	\ ()//. TI
			- 7-	31. Date filed (Month, Day, Year)	10 U	gistrar's Signature	_ \ \ \ \ \ .	10 \	1 mary	and seve	lotigat lon
		Sta Regist		31. Date filed (Month, Day, Year) AUG 1 6 200	4 prints	10 B	sparker				

			ricase	State of Ma						•			C .		
			1 _ For State	State of Ivia	liylari	•		ite of l		INEIII		200	1	250	C 7
			Registrar 1. Decedent's Name (First, Middle, Las				unca	ile oi i	Jeani	2. Date of	Reg. I	No. U	1.0	3. Time of	Death
	Physici	an	1	111.		0	a h	:01	12 V	_ Month		Day Y	ear.	1 11	AM
	/Media	al	4a. Fecility Name (If not institution, give	ctroat and number			4h Cit	y Town or	Location of De		15+	4c. County of	Deeth	1 •	11
	Examir	er			11	1.0	72	. / 11		1: Lu		N/A	20011	_	
	Formul		5. Social Security Number 6. Se	Hopkins	(In yrs.	ast birthday)		er 1 Year	10 (C If Under 24 H	rs. 8. Date of	of Birth		Birthpl	ace (State o	r Foreign
6	Funeral Director		213-68-9665		50	Yrs.	Month	Days	Hours Mi	n. (Monti	n, <i>Day</i> , Yea h 27,	1954		ace (State o try) vland	3
			Usual Residence of Decedent												
	rylan	_	10a. State 10b. County			y, Town or Lo	cation						10	d. Inside Ci	•
	Sa-f	ct	MD Baltimon	re		Essex								1 Yes	2 NO
	ith th	Director	10e. Street and Number					ip Code			10g. (Citizen of Wha	t Count	try?	
	s within 72 hours after death with the Maryland Jene. r then "naturel", or itame 23a or 28a-1 ehow The Medical Examiner must be intiffed at	ra	45 Wiltshire Rd.					21221				USA		1. 4*	
	er de Itami	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		.S. 13.	Was Dec f Yes, sp	edent of Hi ecify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes of orto Rican, etc	r No- .)	14. Race - Black,	White, e	tc.	
36	rs aft	by F	1 ☐ Never Mamied 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	0		1 🗆 Yes	2 XNo	Specify:			Specify:	Whi	te	
윽	hour	edt	15. Decedent's Ed	lucation		16a. Deced	dent's Us	ual Occup	ation		16b.	Kind of Busin	ess/Ind	ustry	
15	n nat	piet	(Specify only highest gra	de completed)	. \	(Give	kind of v DO NOT	vork done d use retired	during most of w ()	rorking		ıblic W			_
212	within plane.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Waste	Wat	er Op	peration	ıs Tech	Pu	IDITC M	OT K	5 рат	. •
Þ	The Try	Bec	17. Father's Name (First, Middle, Last)			,	•		18. Mother's N			en Surname)			
<u>a</u>		To E	Edward N. Schir	ndler Sr.					Gertru	ıde Oli	ver				
Maryland 21215-0036	d 2 should th and Men 7 ie marka traumatic	-	19a. Informant's Name/Relationship (7	ype, Print)			-		and Number or i					Code)	
	1 and 2 Health a	,	Kari J. Burchill	/ Niece	,				/ Ct. Ba	altimor	e Md.	21220			
Baltimore,	S to I I		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	20b. P	lace of Dispo emetery, cren	sition (N natory of	ame of other plac		rust 17	. 11	Location - Cit		vn, State	
Ē	Pag ment ant: I		`4 □Donation 5 □ Other (Specify		0ak	lawn C	emet	ery	20	004	Bal	timore.	MD		
at	permit. Departr Importa eny inj		21. Signature of Funeral Service Licen	See .		22	Char	and Addres	s of Facility Steve	ns Fun	era1	Home T	nc.		
ш_	20599		Thomas.	80			1501	East	Fort A	Ave. Ba	<u>ltimc</u>	re Md.	_21:		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each lin	the death e.	n. Do not ent	er the m	ode of dyin	g, such as cardi	ac or respirato	ry arrest,			Approximate Interval Bety Onset and E	een Neen
	Physician		Immediate Cause (Final disease or condition	, Sep	Sis								0	2mon	This
	/Medical Examiner	3	resulting in death)	Due to (or as a	consequ	uence of):	0 /	• • 4	, 1		0 1		_		
	LAMINITE	_	Sequentially list conditions,	b. Inter	nal	De.	-16	r://a	tor le	ad in	tect	ion	X	mon	HIS
	sit s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	uence or):									
	and I-tran	хап	that initiated events resulting in death) Last	cDue to (or as a	consequ	uence of):									
760,	be executed ician and burial-transit	cal E		220 10 (0. 20)											
687	e X			d											
×	death certifica e attending ph od for use as th	Physician/Medi	IF FEMALE:	23c. If yes, outcome of	of pregna	ncy						23d. Date of	deliver	v	
Вох	atter atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic Other (pregnancy specify)				Month		•	'ear
P.O.	that the de ed by the detached	ıysı	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			· ·	. , , ,							
	requires that the neen signed by th hould be detache	by PI	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in the ur	nderlying	cause give	on in Part I.	23e. t	Did tobacco	use contribu	te to the	cause of de	eath?
ds	quires n sign										☐ Yes	2 □ No 3 □	Proba	bly 4 🔼	nknown
OS	w require been si should b	jete								24a. \	÷ Masan			sy findings a	
Be	The law ate has b page 2 si	Completed									utopsy enformed?	deat	to com h? Yes 2	pletion of ca	iuse of
Division of Vital Records,		C	25. Was case referred to medical						26. Place of D	1 TY		10	195 2	Z LI NO	
>		To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 (1) Inpatier	nt 2 🗆 I	ER/Outpatien	t 3 🗆 E	Othe Othe	AC	Home 5 I		6 ∏Other (Specify)		
0	g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time of		28c. Injury Work	at	*		ury occurred	,,,,,		
<u>o</u>	Attending I r death. ector: After by the funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		/ Oal/	Injury	М		Yes 2 □ No						
Vis	or Attendated after death Director:	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At ho	me, farm, stre	et, facto	ory, office		28f. Locatio	on (Street a	and Number o	r Rural	Route Numi	⊃e <i>r</i> ,
Ö	s after s after al Dire	Certification	4 - Homodo	building, sto.	. (Opeany					Ony or	70117, 010	110)			
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knov	wledge, death	occurre restination	d at the tim	e, date and plac	ce, and due to	the cause	s) and manne	r as sta	ted.	
	To the H within 24 To the F complete	ledi	one)	and manner stat	ed.										
	With To	Σ	29b. Signature and title of certifier	00 - 1 :	1	2aton	1	9c. License				ate signed (M			
•			Lasarta Horana	-medica		OCIOR		1,50	000	<u>.</u>	1109	ust 11	12	004	
	\bigcirc		30. Name and address of person who call Lasanta Horan	completed cause of de	ath (Item	23a) (Type, i	Print)	1==1	B. 1+ :-	re MID	2/2	Pn			
	Λ		1 Date filed (Month Day Year)	22 Bankin	r's Signat	ture .	000	1000	Cuy o mho	, - 17	216	0 /			
*	Sta Registr		31. Date filed (Month Pay Year) § 2	004	da	B	Je.	loose	21						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 2004 Edwin Stale_v August Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 8701-C Yellow Springs Road Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, You Aug. 31, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2□ F 1919 Maryland 84 Director 214-10-1048 Usual Residence of Decedent the Marylend 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examinar rount be notified at 1 ☐ Yes 2 No Directo Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Items 23a or 8701-C Yellow Springs Road 21702 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heath and Mental Hygione. Importent: If Ism 27 is marked other than "natural", or ite eny injury or other traumatic event. The Medical Fusingments Armed Poices? 1 MYes 2 □ No If Yes, Give Year or Dates: 1944-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Company Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lenora Elizabeth Linton Charles Henry Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8701-C Yellow Springs Road, Frederick, MD Margaret Staley, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery | 8/14/2004 Frederick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney and Basford Funeral Home an M. Berger M00999 106 East Church Street, Frederick, MD 23a. Part 1. Finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition **Physician** 15 years disease or condition resulting in death) ASCVD /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown C.A. Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Aortic ABD Aneurism autopsy performed? Yes 2X No 1 Yes after death.

Director: After this certificd in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a filled 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the easis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D31912 August 11, 2004 30. Name and address of person who complet a cause of death (Item 23a) (Type, Print) Julio Menocal, MD, 1564 Opossumtown Pike, Frederick, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 1 6 2004

			1 - For State Registrar	State of Maryland		irtment of F tificate of			giene Reg. No.?	004	25669
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	SEAL				2. Date of De Month UB	Day	2504	3. Time of Death
	Examir	_	4a. Fecility Name (If not institution, give HOWARD WONT)		OSPITA	,	r Location of Death WMS1A			ounty of Death	
	Funeral Director		211 70 7025	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Dec 10	y, Year)	9. Birth Cou Md	place (State or Foreign ntry)
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary B-f sh	tor	Md Howard	We	st Fri	endship.					1 ☐ Yes 🔏 ☐ No
	or 28	Director	10e. Street and Number	1 (D. 1//)		10f. Zip Code			_	n of What Cou	ntry?
	eath w	eral	13896 Frederick Ro	Dad (Kt. 144) 12. Was Decedent Ever in U.S	i. 13. V	21794 Vas Decedent of H	lispanic Origin? (Spe	cify Yes or No	US - 14.	Race - Ameri	can Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinational by notified at an injury or other traumatic event, If a Medical Examination to the recilied at an injury.	Completed by Funeral	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	Rican, etc.)		Black, White, pecily: Whil	
2-0	72 hc	eted	15. Decedent's Edu (Specify only highest grad		(Give	lent's Usual Occup kind of work done OO NOT use retired	durina most of workir	ng .	16b. Kind	of Business/In	dustry
21215-003	filed within 72 Hygiene. Ither than "nai	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	2)		dom	estic	
	be filed stal Hyg od other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			mame)	
Sla	ould b Menta	To 1	Victor Lee Thomps					La Mill			0.4)
Maryland	d 2 shoth and the and the standard traum		19a. Informant's Name/Relationship (T) Luther H. Seal (spe			•	and Number or Rura ick Rd., V				
	es 1 and of Health fitem 27 r other tr		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of natory or other place	, D	ate	20c. Locat	ion - City or To	own, State
altimore,	Pages ment of ant: If it ury or o		1 ♥ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	temoval from State	endree	Cemeter	y 8-17-0	14			ship, Md
Balt	permit. Page Department of Important: If any injury of once.		21. Signature of Funeral Service Licens	d/4. 1 /	22 D	Name and Addre	ss of Facility Hais	ght Fun	eral	Home &	Chapel
	20 0		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death.	Do not ente	U. BOX I	95 Sykesvi ng, such as cardiac of	respiratory a	rrest,	821	Approximate Interval Between
Ž.	Physician		shock, or heart tailure. List only of Immediate Cause (Final disease or condition	NOTE A							Onset and Death
	/Medical Examiner		resulting in death)	Due to for as a conseque	once of):						
	Lamine	e	Sequentially list conditions, if any, leading to immediate	CIPLOWIC OY Due to (or as a consequence)		プロリジ 1º	-I Luman	4 Dise	ASE		3 YEARS
	u ed d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ó,	cate be execu ohysicien and the burial-trar	Exa	resulting in death) Last	Due to (or as a conseque	ence of):						
8760,		dical		d							
9 XO	n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	2c. If yes, outcome of pregnan		Ectopic pregnancy			23d	. Date of deliv	
Division of Vital Records, P.O. Box	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	4☐Pregnant at time of dea		Other (specify)				Month	Day Year
ď	is that pred by e deta	by Pt	Part II. Other significant conditions co.	_	_	nderlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
ord	w requires that been signed to should be det	ted	Concestive		LUILLE			1184	Yes 2□N	lo 3 ☐ Prot	oably 4 □Unknown
Sec	has by	Completed	COR PULMON	Rei				24a. Was autop perfo		4b. Were auto prior to co death?	opsy findings available impletion of cause of
<u>a</u>	ificate or, pag		25. Was case referred to medical				26. Place of Death	1 ☐ Yes		1 🗆 Yes	2 DNO
<u> </u>	Physician: r this certifica ral director, j	To Be	avaminar?	lospital: 1 npatient 2 E	R/Outpatien	t 3 DDA Oth	- International Contraction	-		Other (Special	(y)
0 0	ing Pt After th uneral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	8d. Describe h	now injury o	ccurred	
<u>s</u>	Attending ir death. actor: After by the fune	licati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	ne, farm, stre		Yes 2 No	8f. Location (5	Street and N	lumber or Rura	al Route Number,
<u>≥</u>	afor A after I Dira	Certification:	4 Homicide determined	building, etc. (Specity)		odce are well		City or Tov			
	To the Hospital or Attending Physician: The Within 24 hours after death. To tha Funaral Diractor: Atter this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 ☐ Sertifying Phy 2 ☐ Medical Exami	sician: To the best of my know ner: On the basis of examinati and manner stated.	rledge, death on and/or inv	occurred at the tir restigation, in my o	me, date and place, a pinion, death occurre	nd due to the ed at the time,	cause(s) and date and pla	d manner as s ace, and due to	tated. o the cause(s)
)	To the within To the comp	ž	29b. Signature and title of certifier	Janjan a	~ >	29c. Licens	e number 69.74			igned (Month,	Day, Year)
6			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Print)	NT PARKEN	up cur	umage	A MO	21044
	Sta	ite							· · · · · · · · · · · · · · · · · · ·		
	Regist	_	AUG 1 6 2	32. Registrar's Signatu	1 19	spa	las		_		
DH	IMH 17 Rev 1/2	001									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician august Sanchez 04 bert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Medical Baltimore Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2□ F May 10, 1931 525-58-9243 73 New Mexico **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Ite Modical Examiner wat be notified at 1 Yes 27 No Funeral Director Dunda1k Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3415 Sollers Point Road 21222 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Xes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: þ 3 Widowed 4 Divorced Hispanic Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bathtub Maker Manufacturing 10th. Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ould be fi Eliza 2 Federico Sanchez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Ia m any injury or other traum 90029. 3415 Sollers Point Road Mary Sanchez/Wife Baltimore MD20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/16/2004 Baltimore National Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc 2134 Willow Spring Road Baltimore MD only one cause on each tine. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure List Immediate Cause (Final disease or condition resulting in death) Sersis **Physician** /Medical Due to (or as a consequence of): Examiner Empyema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Non small cell cance lung the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown Be Completed Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ector, page 2 autopsy performed? Chronic Obstructive Pulmonas 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the l Diractor: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 12 2004 A44176435 T14472 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene St. Baltimore MD MD 21201 Christina Turner 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Sever & Speeds Registrar DHMH 17 Rev 1/2001

			_ FOI	epartment of Health and M Dertificate of Death		ene .2004 25671				
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death				
	/Media		CATHERINE	SHINNICK	Mounty OS	10 2004 500 PM				
	Examir	ier	4a. Facility Name (If not institution, give street and number) BAYVIEW HEDICAL CENTER	4b. City, Town, or Location of Death BALTINO 25		4c. County of Death N/A				
	Funeral		5. Social Security Number 6. Sex , 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y					
	Director		220-24-7947 10M 20F 75 YE	s. Months Days Hours Min.	08/10/	1929 MARYLAND				
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location		10d. Inside City Limits				
	Aaryla f sho	ō	MD. N/A BALTII			ty⊒rYes 2 □ No				
	28a-	Director	10e. Street and Number	10f. Zip Code	10g	J. Citizen of What Country?				
	h with	aiD	3722 FAIT AVE.	212	224	USA				
	ems erre	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.				
36	s afte , or it	ру Fu	1 √ Never Married 2 ☐ Married 1 ☐ Yes 2 √ No If Yes, Give 1 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify: WHITE				
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show salest Exacuter mark be notified at	edt	15. Decedent's Education 16a. D	ecedent's Usual Occupation	16	b. Kind of Business/Industry				
215	S - 3	piet	(Specify only highest grade completed) (C	Give kind of work done during most of worki ife. DO NDT use retired)	in <i>g</i>					
21		Completed	10	CLERK		PAINT				
Maryland	a la b y	Be	17. Father's Name (First, Middle, Last)		First, Middle, Ma	iden Sumame)				
3	should be ind Mental s marked o umatic ev	2	ANDREW SHINNICK 19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rura	A MATHIAS	Situ or Town State Zin Code)				
Ma	tre tre			80 VICTOR DR., SYKES						
	is 1 end of Heelth Item 27 other ti		20a. Method of Disposition 20b. Place of D			c. Location - City or Town, State				
Ë	Page nent o nt: If ry or		1 XBurial 2 □ Cremation 3 □ Removal from State SACRED]	HEART OF JESUS 8/14	4/04 B	ALTIMORE, MARYLAND				
Baltimore,	permit. Pages Department of I Importent: If Its any Injury or of		21. Signature of Funeral Service Licensee Cualith Evans	22. Name and Address of Facility CHA 6224 EASTERN AVE.,						
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac c	or respiratory arrest	Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition			Onset and Death				
	/Medical Examiner		resulting in death) Due to (or as a consequence of).							
	LAGIIIIIei	_	Sequentially list conditions, if any, leading to immediate b. ISCHEMIC Due to (or as a consequence of):	ONEMONTH						
	ned nsit	nine	cause. Enter Underlying Cause (Disease or injury							
Ć.	te be executed ysicien and se burial-transit	Examine	that initiated events c, resulting in death) Last Due to (or as a consequence of):							
8760,	icate be executed physicien and s the burial-transit	icai	d							
9	artifica ing ph	Physician/Med	IF FEMALE:							
Вох	law requires that the death certifics es been signed by the ettending ph 2 should be detached for use es t	lan/	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy		23d. Date of delivery Month Day Year				
P.0.	res that the de signed by the e be detached f	ysic	1 ☐ Yes 2 MNo 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)						
	that i	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?				
rds	w requires been sign should be		COLONARY ARTERY DISEASE		1 🗆 Yes	2 No 3 Probably 4 Winknown				
Records,	e law re hes bee	piet	ATRIAL FIBRILLATION		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of				
	The ate h	Completed	CEREBROVASCULAR DISEASE		performed	death?				
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death						
of	d is	10 To	1		me 5 Residence					
uo	ding h. After funer	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year) Inju		Edd. Describe now	injury occurred				
Division	Attending Physician: r death. sctor: After this certificaby the funeral director, i	Certification:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm			at and Number or Rural Route Number,				
á	s efte	Cert	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S	rare)				
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After th completely filled in by the funeral	edicai (29a. Certifier (Check only one) 1 ☑ Certifying Physicien: To the best of my knowledge, d 2 ☐ Medical Exeminer: On the basis of examination and/o and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)				
•	3		Mulule Maushan	RES-000		08/10/2004				
	5		30. Name and address of person who completed cause of death (Item 23a) (Ty MICHELE MANAHAM, 4940 EASTERN AVEN	pe. Print) VUE, BALTIMORE, N	EIR OL	λÝ				
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	M.						

DHMH 17 Rev 1/2001

			_ For	State of Marylar	nd / De	partment of I	Health and N	lental Hy	giene		
			1 - State Registrar		C	ertificate of	Death	F	Reg. No.	AL.	25672
	Dhusisi		1. Decedent's Name (First, Middle, Last)	TI				2. Date of Dea	ith , Day	Year	3. Time of Death
	Physici /Medic		Arthur E	, Ihoma:	2			AUGUS 1		2004	10:09PM
	Examin		4a. Facility Name (If not institution, give s		14-	1	or Location of Death			ity of Death	
			VA MARYLAND HEN 5. Social Security Number 6. Sex	9LTH CARE 54 7. Age (In yrs.			Point If Under 24 Hrs.	8. Date of Birt		CIL	
	Funeral Director			M 2□F Q C	. rasi birind Yrs	Months Days	Hours Min.	Month, Day	Ygar 19	9. Birth	nplace (State or Foreign
			Usual Residence of Decedent					Daig	11-1-		rginia
	rylan	_	10a. State 10b. County	10c. Ci	ity, Town o	r Location					10d. Inside City Limits
	Ba-f s	cto	Maryland N/A		Bal	timore					1 Yes 2 No
5	vith th	Dire	10e. Street and Number	1/	0+	10f. Zip Code	511		10g. Citizen o	f What Cou	untry? 1
<u> </u>	death with the Maryland ms 23a or 28a-f show rmust be redified at	eral	1420 N. DO	Sedale 12. Was Decedent Ever in U	01	13 Was Danadant of h	LIG	acifu Vac or No-	14 8	ST	ican Indian,
V	tter de	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 □ No	J.J.	 Was Decedent of H If Yes, specify Cub 	an, Mexican, Puerto	Rican, etc.)	BI	lack, White	
% <i>₹</i> %	72 hours after naturel', or Ite	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Spec	ity: RL	ack
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2 4 2 E	filed w Hygie ther ti	S	17. Father's Name (First, Middle, Last)		1	Idilor	18. Mother's Nam	e (First Middle	Selt Maiden Sum	T_[nployed
3 7,5	d be fantal h	Be c	11/-11	as			Flore	6 C C	Tolo	10 5	
3 2	should nd Men marke imetic	T ₀	19a. Informant's Name/Relationship (Type	118 1-2 1) 19b. M	ailing Address (Street	and Number or Rur	al Route Numbe	r, City or Tow	n, State, Zi	ip Code)
505	and 2 salth a n 27 Is		Mrs. Geraldin	ie Cotton	15	12 Popl	ar Gri	NE ST	F.Pa	Hol	11.21216
1/2 5	of He		20a. Method of Disposition	I .	Place of Di cemetery,	sposition (Name of crematory or other pla		Date	20c. Location	ı - City or T	own, State
NAME // altimore.	Page nent ent: If ury o		1 X Burial 2 ☐ Cremation 3 ☐ Ri '4 ☐ Donation 5 ☐ Other (Specify)		arris	Son For	25+ 0/20	12004	Wine	is M	ills. Md.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan pepartment of Health and Mantal Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumetic event, the Medical Examinat must be notified at once.		21. Signatore of Funeral Service Cense			22. Name and Addre	ss of Facility	Finer	7 L	ame	
ω	20599		posleph	J. Bus		2222 WI	North A	ve B	alto.	ma.	21216
		,	23a. Part . Enter the disease, or complice show or heart failure. List only on	cations that caused the dea ne cause on each line.			ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	PROSTAT		ANCEL					
	/Medical Examiner			Due to (or as a consec	quence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					_	unknown
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							1	
o.	an an		resulting in death) Last	Due to (or as a consec	quence of):						
8760.	cate be executed physician and s the burial-transit	dlcal	€ d								
9			IF FEMALE:	0-14							
Box	w requires that the death certifices on signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta	al death	3 Ectopic pregnanc	у			ate of deliv fonth	rery Day Year
10	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of o 9☐Unknown	Death	5 ☐ Other (specify) _					
1/4	that the led by detac	y Ph	Part II. Other significant conditions con	tributing to death but not res	sulting in th	e underlying cause gr	ven in Part I.	23e. Did to	bacco use co	ntribute to 1	the cause of death?
Sp	quires than signed	d by						1 □ Y	es 2 🗆 No	3 ☐ Pro	bably 4 E Unknown
Record	aw requ s been 2 shouk	Completed						24a. Was a		. Were auto	opsy findings available
28	The ta	mo						autops perfor	ned? 2 No	death?	ompletion of cause of
/g <u>ia</u>	len: artifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Deat				
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Division of Vital	ding Physicien: The lav. h. Affer this certificate has funeral director, page 2	lon:	27. Manner of Death 1 ➤ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	ry Wa		28d. Describe h	ow injury occu	rred	
isio	uttendi death. ctor: A y the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	nome farm		Yes 2 □No	28f Location (Si	reet and Num	ther or Rur	al Route Number,
Ο̈́	or Attend after death Director: ,	Certification:	4 Homicide determined	building, etc. (Special	ify)	stroot, ractory, office		City or Town	n, State)	00, 0, 1,0,0	27770310 17071001,
	Hospitel or Attending Physicien: The law requires that the death certif 4 hours after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use as			sician: To the best of my kno							
	To the Hospitel or Attend within 24 hours after deall To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medicel Examin	ner: On the basis of examina and manner stated.	ation and/o	r investigation, in my o	opinion, death occurr	ed at the time, d	ate and place	, and due t	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licens		2	9d. Date sign	ed (Month,	Day, Year)
	, Li		1/MIC			125	7239		8/11/	04	
	1 To		30. Name and address of person who con		m 23a) (Ty	pe, Print) [AAYLAND	1/0	- C		0	. O. L
	¥ Sta	10	Surcsh Jhander	22. Registrar's Signa			MEALTH C	HRE Sip	TEM !	ERRU	1 FOINT
	Sta Registr		AUG 1 6 2004	Andre II							
			, 10 d ± 0 £004	Supering Allendary	100	DATE OF THE PARTY					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** TUSCANO 17=06 DAN AUGUST 2004 11 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner IF AL FOLD USF UNCHEDAPEAKE MEDICALLENTOL BEZAIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/4/1932 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2K F 72 213-28-9578 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "naturel", or Iteme 23a or 28e-f show treumatic event, the Medical Exercition mastic profiling at 1 ☐ Yes 2 ▼ No Director Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 313 C Laurel Woods Dr. U.S.A. 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-003 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Lyla Aiken Horace Schmelz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Depertment of Health a Importent: If Item 27 Is any injury or other tree once. 313 C Laurel Woods Dr. Abingdon, Maryland 21009 Richard J. Tuscano Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 8/16/04 Baltimore, Maryland Gardens of Faith * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licenses 6415 Belair Road Baltimore, maryland 21206 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final JUNSHOT WOUND TO CHEST **Enysician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEZF INFLOCTEM Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Moknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ♣ 0 24a. Was an autonsy page performed' 1 ☐ Yes 2 No Vital F director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 ¥es 2 🗌 No 2 this funeral 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification; After t or Attending 1 Natural 5 Pending SERF INFLICTED death. 16=00 M 1 Yes 2 No investigation Augil 2004 2 Accident within 24 hours efter death To the Funeral Director: 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Pluce of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) wood munzion 3136 Lourd HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier 021809 DME 11, 2004 unst

State Registrar

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32. Registrar's Signature

2336 YORK NO TIMONUM MO ZION3

Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRASHUMO

AUG 1 3 2004

			For State Registrar	State of Maryland		rtment of H			iene g. No. 0 0 4	25674
	Physicia	20	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Year	3. Time of Death
	Physicia /Medic			avier Welsh				August	08 2004	11:05 a ^M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County of Dea	
			8820 Walther Bl 5. Social Security Number 6. Sec		st birthday)	Baltimor	If Under 24 H	rs. 8. Date of Birth	Baltimo 9. Bir	thplace (State or Foreign buntry)
	Funeral Director		213-01-0903	M 2□F 85	Yrs.	Months Days	Hours Mi	March 24	1, 1919 M	arvland
	pu ,		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Lo	nation				10d. Inside City Limits
	show	2	Md. Baltimo		timore					1 Yes 2 No
	ith the Marylar or 28a-f show e notified at	Director	10e. Street and Number	TE Dai	CIIIOI	10f. Zip Code		10	Og. Citizen of What Co	l
	3a or	١	8820 Walther	Blvd. #4118		21234				USA
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V		spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
9	after or ite	F.	1 Never Married 2 Married	1 Types 2 No		Yes 2/ No	Specify:	onto rilicani, otc.,	Specify: Wh	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-i's how than "call Exemiter main be notified at	d by	3X Widowed 4 Divorced	Year of Dates:	100 Deced	lent's Usual Occupa	l lon		16b. Kind of Business	
15	n 72	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	kind of work done d DO NOT use retired)	luring most of w)	vorking	160. Killu of Business	midusity
212	d withi	omb	Elementary/Secondary (0-12)	College (1-4or 5+)	Air	craft Mec	hanic_		Airline	
ğ	e filecal Hyg	BeC	17. Father's Name (First, Middle, Last)					ame (First, Middle, A		
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla II of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 shou or other traumatic event, the Medical Examiner must be notified at	To	Thomas J. Welsh					zabeth 0'N		
Jar	12 sho	i	19a. Informant's Name/Relationship (Ty						City or Town, State,	
	1 and 1 Health Iem 27	1 8	Marjorie C. Strar 20a, Method of Disposition	na Niece 20b. Pla	ce of Dispo	Boggs Roa sition (Name of natory or other place	ad Foi	rest Hill,	Maryland 20c. Location - City or	21050 Town, State
Б	Pages nent of i		1 Surial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	tellioval irotii State		natory or other place /alley Mei		1-04	Timonium	. Md.
Baltimore,	permit. Page Department o Important: tf any injury or once.		21. Signature of Funeral Envice Licens		22	Name and Addres	s of Facility On Fune	ral Home,	Inc.	,
	40544		23a. Part1. Enter the disease, or compl	ications that caused the death		LO50 York	_RdTo	wson. Md.	21204	Approximate
	*	-	shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	1		1			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque		-erative	010	order		Month
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		ner	Eagueritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):					
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	s						
,092	te be executed ysician and ne burial-transit	E	resulting in death) cast	Due to (or as a conseque	ence or):					
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan					23d. Date of de	livery
B.	death e atte	iciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea		lEctopic pregnancy Other <i>(specify)</i>			Month	Day Year
P.0	t the by the tache	hys	9 Unknown	9□ Unknown						
	es tha	by F	Part II. Other significant conditions co	, ,		nderlying cause give	en in Part I.		pacco use contribute to	
Records,	w require been si should b	ted	CPU , C10	has diseat				1 □ Ye		
Sec.	e law has b	nple						24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of
a F	sician: The law certificate has b irector, page 2 s							1 ☐ Yes 2	1 No 1 □ Yes	2€10
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outnatien	t 3 DOA Othe		Home 5 Reside	nce 6 □Other (Spe	cifu)
o	Attending Physician: r death. sctor: After this certification in the funeral director.	n: To	27. Manner of Death		28b. Time of Injury	28c. Injury Work		28d. Describe ho		ony)
ion	ath. or: Aft	atio	1	(MOTHER, Day 1641)	injury		Yes 2□No			
Division	r Atte	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the to	Medical Certification:	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sicien: To the best of my know ner: On the basis of examination and manner stated.	on and/or in	estigation, in my op	pinion, death of	curred at the time, da	ate and place, and due	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier	7 0		29c. License	number	25	9d. Date signed (Mont	h, Day, Year)
	- > F 0		> / /a /	5 ma		05	3117	F	furust 9th	2004
14	5ti		30. Name and address of person who c		23a) (Type,	Print)	0 1	ville m	0 712811	
/-	/ / 1		JEFF Condimon		Ithe	- 11-0	1'alk	ville M	0 -1209	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signaty	The A	oaks				
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	Physici /Medio		1. Decedent's Name (First, Middle, Last) Robert L. Wilkinson		2. Date of Death Month August	13 2004	3. Time of Death 7:25 a M
	Examir		4a. Facility Name (If not institution, give street and number) Gilchrist	4b. City, Town, or Location of Death TOWSON If Under 1 Year If Under 24 Hrs.		4c. County of Death	re
	Funeral Director		5. Social Security Number 170-07-3906 C. Sex 1 M 2 □ F 92 Yrs. 12 M 2 □ F 92 Yrs. 12 M 2 □ F 17. Age (In yrs. last birthday) 92 Yrs. 18 M 2 □ F 18 M 2 □	Months Days Hours Min.	8. Date of Birth Month, Day July 20,	9. Birth	nplace (State or Foreign Y and
2/2	e Maryland Sa-f show	ctor	Md. Baltimore Spark				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
3,700	ath with th	rai Dire	10e. Street and Number 14211 Quail Creek Rd. #208	10f. Zip Code 21152		Citizen of What Cou	
August 13,2004 15-0036 0726	permit. Pages I and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Example; must be invitible at once.	by Funeral Director	1 □ Never Married 2 1 ☑ Married 1 □ Yes 2 1 No	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
7	within 72 ho ene. than "natu he Medical	Completed	Flamentary/Secondary (U-12) College (1-4or 5±)	ent's Usual Occupation kind of work done during most of work OO NOT use retired) crical Engineer	ing 16	b. Kind of Business/li Engineeri	•
(WS0)	uld be filed fental Hygir rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Robert Otha Wilkinso	18. Mother's Name	e (First, Middle, Mai	iden Sumame)	nes
Wilk Mary	and 2 should ealth and Men n 27 is marke ier traumatic		Mrs. Wanda Laird Wilkinson/ Wife 1421	g Address (<i>Street and Number or Rura</i> 1 Quail Creek Rd.			
Robert Wilkinson Baltimore, Maryland 2121	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, the Mones.			alley Mem. 8-17-	04 T	c. Location - City or T 「imonium,	
(左區	permi Depar Impor any ir		21. Signature of Fundial Solice (License) 22.	Ruck Towson Fune 1050 York Rd. To	ral Home, wson, Md.	Inc. 21204	Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only or cause on each line. Immediate Cause (Final disease or condition resulting in death) a	and on your at			Approximate Interval Between Onset and Death
dh		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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rds, P.	w requires that the de been signed by the s should be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	3.	co use contribute to t	the cause of death?
I Reco	The law re- ate has bee page 2 sho	Completed			24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Active Service		n (Check only one) me 5□ Residence 28d. Describe how in	<u> </u>	mhospice
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, St	t and Number or Rura fate)	il Route Number,
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	Twiting to the second s		29b. Signature and title of certifier	29c. License number	A	Date signed (Month, GUSF 13	2004
	(¢	e.	30. Name and address of person who completed cause of death (Item 23a) (Type, P ARON CALLES, M.) (GC) N, C 31. Date filed (Month, Day, Year) 32. Registrar's Signature	follos St Beltin	nine me) Z1204	
DHI	Registra 	ar	0110	Sparky.			
			ORIGINAL				

Michael Willey Jr. Unpend item # 23a, 27, 28a-1, per his, 634, by 2 hy64, Engure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene MES State Registrar # 16b, per FH, G834, 8/23/04 Toertificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Michael Patrick Willey, Jr. a M 6 2004 6:05 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 29371 Connelly Mill Rd. Delmar If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7-27-1977 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F Yrs. 27 Md. Director 220-17-2168 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 ☐ Yes X☐ No Director Md. Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 21875 USA 29371 Connelly Mill Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Plating Company 12 Plater 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael P. Willey Judy Alexander Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 Is 29371 Connelly Mill Rd. Delmar, Md. 21875 Michael P. Willey, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 8-11-04 Powellville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tacture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Narcotic Intoxication **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 1 Yes 2 🗆 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 ☐ No 4 Nursing Home 5 Residence 6 Rether (Specify) At Scene 2 this 28a. Date of In Found 28b. Tim Found 28c. Injury at (Month. Day ear Liquey Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 5:45 a M Unknown 1 Yes 2 No 8/6/04 investigation within 24 hours after death. To the Funerel Director: 2 Accident 6 Could not be determined filled in by the 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office Found. 28f. Location (Street and Number or Rural Route Number, 29321 Connally Mill Road 4 Homicide Delmar, MD

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Hospitel 29a. Certifie Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME August 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEMOREME 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 1 6 2004

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. E	Ensure All Copies Are Legible.
State of Maryland / Department of Hea	alth and Mental Hygiene

		-	For State Registrar		State of	f Marylan		artmen rtificate			and M		giene		and the same of th	25677
	sicia		1. Decedent's Name Louis	(First, Middle, La Andrycho	•							2. Date of De Month	ath Day	,	Year	3. Time of Death 2:45 P.M
	ledica Imine		4a. Facility Name (If r			nber)	Ě	4b. City,	Town, or	Location o	of Death	AUGUST			2004 of Death	Z:45 P.
			VA MARYL	AND HEAL	TH CARE	SYSTEM	1		PERR	RY POI					CECII	
Fune Direc			5. Social Security Nur 214-18-65	00	M 2□F	7. Age (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir May 20,	192	1	9. Birthpl Count Mary	ace (State or Foreign ry) Tand
land	4	-	Usual Residence of D 10a. State	10b. County		10c. Cit	y, Town or Lo	cation							10	Od. Inside City Limits
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ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If them 2715 marked other then "naturel", or thems 23a or 28a-1 show the trainmails asked the them.	Age of the	by Fun	1 Never Married 3 Widowed 4		Armed For 1 Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 🗌 No e		f Yes, spec		Specify:	, Puerto I	cify Yes or No Rican, etc.)			k, White, e	etc.
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odiffiliore, Mi ermit. Pages 1 and 2 epartment of Health of Importent: If then 27 It		-	20a. Method of Dispo 1 ⊠ Burial 2 □	sition Cremation 3	Removal from S	20b. P	Place of Dispo emetery, crem	sition (Nan natory or o	ne of ther place	9)	D	ate	20c. Lo	cation -	City or Tov	
ermit. Pages epartment of mportent: If the partment of mportent: If the partment of the partme	in in	-	` 4 ☐ Donation 5			pula	ney Vall	ey Men				04			n, MD York F	2004
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To the Hospitel or within 24 hours effe To the Funerel Director Indian in commitments in the filled in	neily miles	edical Ce	29a. Certifier 2 (Check only 2 one)	CCertifying Ph ☐ Medical Exar	niner: On the ba	isis of examina	wledge, death tion and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	nd due to the d at the time,	cause(s) date and	and mar	nner as sta and due to t	ted. the cause(s)
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	be illed within 72 hours after death with the Maryland Hygiene. A let Hygiene. A chief then "natural", or items 23a or 28a-f ehow do ther than "natural", or items 23a or 28a-f ehow event, the Madical Evantral must be notified at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dece	dent of His	panic Origin? (S	Specify Yes or No to Rican, etc.)	. 14	1. Race - Ame		,
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Вох	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 □Ectopic p				23	d. Date of deli Month	ivery Day	Year
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Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other		ath (Check only o				
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lon	Attending r death. sctor: After oy the fune	ation	1 Datural 5 ☐ Pending 2 ☐ Accident investig		y Year) In	jury M	Work'	? es 2 □ No					
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	thin 2 the or the	Med	one) 29b. Signature and title of certifier	and manner sta	ated.	29	c. License	number		29d. Date	signed (Month	n, Day, Year	-)
ł	₩		PATRICK LE	E M.D.			PI	7618			-13-		
^			30. Name and address of person v	who completed cause of d	eath (Item 23a) (Type, Print)				0	15-	200	-
1			PATRICK LEE	22 South	hreene S	A Bult	imore	MO 21	201				
	Sta		31. Date filed (Month, Day, Year)	22 S:x4-1	ar's Signature	1 /		,					
	Registi	rar	AUG 1 7 2	004	5	ppo	uns						

			1 For State Registrar	State of M	aryland / Do	epartment o			ental Hy	/giene Reg. No 2 (1 (1)	
	9		Decedent's Name (First, Middle, Last) 2. Date of Death								3. Time of Death
	Physici		JUSTIN A	ALAN ARROWOOD					Month O	9 Day 12 Ye	2 55 PM
	/Medic Examin		4a. Facility Name (If not institution, giv				n, or Location	of Death	,	4c. County of D	
			UNIVERSITY OF M	ARYLAND	MEDICAL	SYS BA	ALTIM	ORE		BAL	TIMORE
	Funeral		5. Social Security Number 6. S	Sex 7. Ac	ge (In yrs. last birth	day) If Under 1 Yo	ear If Under		8. Date of Bi	rth 9.	Birthplace (State or Foreign Country)
L	Director		220-09-1423	12M 2□F	Yı	s. Moritis Da	Bys Hours	MIII.	07/1	9/2004	VSA
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Lagation					
	sho	ö		2020	V 100						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
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	with Ba or	<u>=</u>	11345 Pulaski High	Tax Lot //	4		16			10g. Citizen of What	Country?
	leath	era	11. Marital Status	12. Was Decedent		21162 13. Was Decedent	of Hispanic Or	rigin? (Spe	oifu Vae or No	U.S.A.	merican Indian,
(0	r Iter	Funeral Director	1 Never Married 2 Married	Armed Forces?)	If Yes, specify (Cuban, Mexica	n, Puerto F	Rican, etc.)	Black, W	
03	al', o	ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 2√2	No Specify:	:		Specify:	White
5-0	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examiner must be inclifted at	Completed	15. Decedent's E. (Specify only highest gra	ducation	16a. D	ecedent's Usual Oc	cupation			16b. Kind of Busine	ss/Industry
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2	filed with Hygiene. other ther	S	N/A			N/A				N/A	
ind	d ta b	Be	17. Father's Name (First, Middle, Last,				18. Mothe	er's Name	(First, Middle	, Maiden Surname)	
Yla	should be ind Mental marked o	ို	Lloyd K. Arrowoo						M. Arm		
Maryland 21215-0036			19a. Informant's Name/Relationship (Barbara M. Armes/		19b. N	Mailing Address (Str	eet and Number	er or Rural	Route Numb	er, City or Town, State	a, Zip Code)
ത്	l an Heal Im 2 Ther		20a. Method of Disposition			isposition (Name of			OL 46,		sh, MD 21162
Baltimore,	ages nt of : If it		□ Burial 2 □ Cremation 3 □		cemetery,	crematory or other	place)			20c. Location - City	or lown, State
∄	it. Pa		' 4 Donation 5 Dother (Specification 1.1)		Cedar H	ill Cemet		8-17-		Brookly	
Ba	permit. Pages. Department of F Importent: If ite eny injury or of	1	at Wine Co	IDAG M		2719 Hamm	onds F	erryR	đ., La	nsdowne, M	f Lansdowne D 21227
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the death. Do not ne.	t enter the mode of	dying, such as	cardiac or	respiratory a	rrest,	Approximate Interval Between
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Вох	death certific e attending p od for use as	Physician/Me	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal death	• C =				23d. Date of o	lelivery
	0 0	sicia	in the past 12 months? 1 □ Yes 2 ☑ No	4 ☐ Pregnant at		3 ☐ Ectopic pregna 5 ☐ Other (specify)				Month	Day Year
P.O.	that the de ed by the detached	hy	9 🗆 Unknown	9□ Unknown							(
	se us	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in th	ne underlying cause	given in Part I.		23e. Did to	obacco use contribute	to the cause of death?
ord	w requir been si should	ted							1 🗆 '	Yes 2 No 3	Probably 4 Nnknown
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E H	ate pag	Cou							perfo	rmed? death	?
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of	is is	. To	1 Yes 2 No 27. Manger of Death	Hospital: 1 Inpatie		MIGHT 3L DOA				dence 6 Other (Sp	pecify)
on	ting After fune	tion	1 ■ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tim y Year) Inju		njuryat Vork? □Yes 2□I	1	Id. Describe f	now injury occurred	
Division	I or Attending after death. Director: After in by the fune	fica	2 Accident investigation 3 Suicide 6 Could not be		ury - At home farm				of Location /9	Street and Number or	Chum I Cauta Mumbas
É	in the	Certification:	4 Homicide determined	nined 286. Place of Injury - At nome, farm, street, factory, office 28f. Locatio						vn, State)	nurar noute wuriber,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	r examination and/d	eath occurred at the r investigation, in m	e time, date and ly opinion, deat	d place, an	d due to the d	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Lice	ense number			29d. Date signed (Mo	nth, Day, Year)
			* Framily	MD		D	0059	160		08/1	2/2004
١			30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print) 22 :	SOUTH	GRE	ENE	STREET	1
1			SAN;			N5	W 68	BACT	rimori	E MD 2	21201
1	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	books					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 15 2004 Austin 7:55 PM Mary Elizabeth August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring Sunrise Assisted Living If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1□M 2XF Hours 86 Yrs. Dec. Director 19,1917 Tennessee 410-28-8026 Usual Residence of Decedent with the Marylend 10c, City. Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Example, or items to 1 Yes 2XXNo Montgomery Maryland Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11612 New Hampshire Ave. 20904 United States Completed by Funeral iled within 72 hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Administrative Assistant Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill iment of Health and Mental Hillent: If item 27 Is marked other Be Clarence Hilliard, Sr. Mabe1 Grover Riggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Oma M. Higgins / Sister 100 Quaint Acres Dr., Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State August 17, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ö permit, Page Depertment of Importent: If any injury or once. Chesapeake Crematory 2004 Beltsville, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral and Cremation Services Moo382 933 Gist Ave., Silver Spring, MD 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate the sequence of the Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗓 No Day 5 Other (specify) 4□Pregnant at time of death detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Dementia has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy 2X No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Certification: To 1 ☐ Yes 2 🏋 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospitel 24 hours a 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #205; Takoma Park, MD 20912 Nasree Kango, M.D.; 7610 Carroll Ave., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Elmer Austin August 15, 2004 2:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3062 Nova Scotia Road Bel Air Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 3M 2□ F Days Hours Min. Director 86 Yrs. 372-03-7686 Jun 28, 1918 OH Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. Count 10c. City, Town or Location 27 is marked other than "netural", or Items 23a or 28a-f show treumatic event, the Madical Examinar must be excelled at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No Harford Bel Air 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3062 Nova Scotia Road 21015 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 41 - 42 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ent: if Item 27 is marked other than ' Elementary/Secondary (0-12) Steel College (1-4or 5+) Millwright 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Hoaq Austin Hazel Marie Benton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Austin/Wife other 3062 Nova Scotia Road, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State ö permit, Page Department of Importent: If any injury or once. Aug 16 ¹ 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory Beltsville, MD 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00986 Cremation and Funeral Alternatives - Hule 8717 Green Pastures Drive Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 13chemic Cardioun disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown þ ete has been signed page 2 should be dei Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. I Director: / d in by the f investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) H0054439 August 16,2004 Mich 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincena A Giminero Do SiAtion Rd. Bel Air MD 21015 602 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2004

ORIGINAL

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>	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) GEORGIANNA BOLDEN 4a. Facility Name (If not institution, give street and number) STELLA MORRIS	4b. City, Town, or Location of Death BALTIMORE	2. Date of Death Month Da 1494ST 46	Year 4. SO P M County of Death A
	Funeral Director		5. Social Security Number 213-18-1534 6. Sex 1 M 2 F 7. Age (In yrs. las	st birthday) If Under 1 Year If Under 24 Hrs. 8 (Yrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Year)	
	a-f show	ctor	10a. State 10b. County 10c. City,	Town or Location BALTI MORE		10d. Inside City Limits 1⊠Yes 2 ☐ No
	ath with the 23a or 26	Funeral Director	10e. Street and Number 4626 MARBLE HALL ROAD	10f. Zip Code 21218		tizen of What Country?
250	n 72 hours after death with the Marylar "naturel", or Items 23a or 28a-f show culcul Exattrities tourst be motthed at	by	11. Marital Status 1 ⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	. 13. Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Rid 1□ Yes 2⊠ No Specify:	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
0-6121	be lied within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. do chfer than "naturel", or Items 23a or 28a-f show event, the Medical Exattrine must be mailted at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12+h grade College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	7	and of Business/Industry
מומ	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, Itams	Be	17. Father's Name (First, Middle, Last) Preston Bolden	18. Mother's Name (I	First, Middle, Maider	
lal y	2 should be and Mental Is marked or reumatic ever	스	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural F	Route Number, City	or Town, State, Zip Code)
ע	permit. Pages 1 and 2 should Department of Health and Men Importent: if Item 27 Is marke any injury or other treumatic. QDE8.		20a. Method of Disposition 1 % Burial 2 Cremation 3 Removal from State	1933 Vernon Ave . Bace of Disposition (Name of metery, crematory or other place)	te 20c. L	ocation - City or Town, State
	permit. Pages Department of I Importent: tf its any injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee			altimore, ND
ă	Per la fill de la fill		23a. Part 1. Etter he disease, or complications that caused the death.	22. Name and Address of Facility CAUSIN C. GREENE FUN 5151 BA Himole NAtio NA Do not enter the mode of dying, such as cardiac or r		Approximate
	Physician /Medical Examiner		shock, or neart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque	tastatic Lung Ca	rcino	Interval Between Onset and Death
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence control of the			
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.O. DO.	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as if	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
COINS, L	w requires that been signed b should be deta	by	Part II. Dther significant conditions contributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
on or vital	ng Phy fter this meral o	ıtlon: To Be				6 X ther (Specify) HTSPICE ry occurred
	To the Hospital or Attendi within 24 hours after death. To the Funerel Diractor: A completely filled in by the fu	Certification:	a Could not be	ne, farm, street, factory, office	ff. Location (Street ar City or Town, State	nd Number or Rural Route Number, a)
	ne Hospi 24 hour ne Funer detely fill	edical	29a. Certifier (Check only one) 1	rledge, death occurred at the time, date and place, and on and/or investigation, in my opinion, death occurred	d due to the cause(s I at the time, date and) and manner as stated. d place, and due to the cause(s)
)	To the within To the comp	M	29b. Signature and title of certifier	29c. License number 007930	29d. Da	ate signed (Month, Day, Year)
1			30. Name and address of person of completed cause of death (Item 2	23a) (Type, Print) = T-407 PiA+T+A+1	THE MIT	gust 16,2004 > 21202
Ì	Sta Registi		31. Date filed (Month, Day, Year) ALIG 1 7 2004 32. Registrar's Signatu	To Spale	100	/ V Low Comp

			1 - State Registrar	•	artment of Health and M rtificate of Death	lental Hygier Rag.á	2001. 9	25683				
			Decedent's Name (First, Middle, Last)			2. Date of Death	lav Voar	3. Time of Death				
	Physici /Medic		Curtis Bradl	ey		August 1	1 2004	0555 A				
}	Examir		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		c. County of Death					
			Northwest Hospital		Randallstown		Balti					
М	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	r) 9. Birthpl Count	ace (State or Foreign				
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	land ow		10a. State 10b. County	10c. City, Town or Lo	ocation		10	Od. Inside City Limits				
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	28a	rec	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Coun	try?				
	3a or	<u> </u>	21 Richmar Road Apt.	K	21117	т	Jnited Sta	tes				
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show deat Examiner must be notified at	Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - America	an Indian,				
9	after or Ite		1 Never Married 2 Married 1 X	es 2 No 7-26-60	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, e					
03	rali, o	d by	3 ☐ Widowed 4 X Divorced Year	or Dates: 7-12-63	1 ☐ Yes 2 X No Specify:		Specify:	White				
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	lled v lygie her t	ပိ	12 17. Father's Name (First, Middle, Last)		Mechanic 18 Mother's Name	(First, Middle, Maid	as Statio	n				
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Ma	id 2 s ith an 27 is trau				220th Street, Pas							
<u>6</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Location - City or To	wn, State				
OL	ages ant of nt: If i		1 urial 2 Cremation 3 Removal f	om State MD Vetera	natory or other place) in Cemetery	6-2004 Cr	ormariilla	MD				
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Second Lique (00		2. Name and Address of Fackinbro							
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87	cate be executed physician and the burial-transit	dlcal	d.									
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Вох	death certiff e attending id for use as	cian	in the past 12 months?	ive birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year				
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00	~ Q 70	olete				24a. Was an	24b. Were autop	sy findings available				
Be	0 4 0	Completed				autopsy performed? 1 ☐ Yes 2 ☐	death?	npletion of cause of				
Vital	ician: Th certificate ector, pag	(a)	25. Was case referred to medical		26. Place of Death		10 103	20140				
f V	dis s	To B	examiner? 1 Yes 2 No Hospital:	Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
n of			27. Manne eath 28a. D	Pate of Injury 28b. Time of Month, Day Year) Injury	f 28c. Injury at Work?	28d. Describe how in	ury occurred					
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Division	or At fter d jirect in by	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. F	lace of Injury - At home, farm, str uilding, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, Sta		Route Number,				
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	Tailed	29c. License number	29d. C	ate signed (Month, E	Day, Year)				
	⊢s⊢ō		Dr Jameston	1	HOOT1226	Δ .	11 et 11 -	road				
n			30. Name and address of person who completed	cause of death (Item 23a Type,	Print)	Tu	Jus, 11,					
D		'	Dr. Lawater en 5401	od ct. Rd. Rav	rdallstownWD Z11	33						
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	make!							
	Regist	rar	AUG 1 7 2004	1 19								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:15 AM BENNET ER NON 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5,000 SAMARITAN HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Apr 19, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**⅓**M 2□F 212-26-0352 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show th and Mental Hygiene. ?? Is marked other than "natural", or items 23s or 28s-1 show traumatic event, the Medical Examinar must be modified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give 2 No 1 Never Married 2 Married unk 1 Yes 2 No Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unk of Health and N: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 21239 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. '4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, MD 21201

23a. Part1. Enter the disease, or emplications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAILURE Physician /Medical ASPIRATION PNEUMONIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: N/A 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HEART FAILURE 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpatient 28d. Describe how injury occurred 27. Manner of Death Natural 5 Pending death. investigation 2 Accident within 24 hours after death To the Funerel Director:, completely filled in by the t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier . P. Momas MD 08/05/2004 D0060687 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCHRAVEN BUND, BALTIMORE, MD - 21239 SONY MTHOMAS

State Registrar

31. Date filed (Month, Day, Year) AUG 1 7 2004

5601 32: Registrar's Signature

or Attending Physician: The law requires that the death certificate be executed

the Hospitel

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

			1 - For State Registrar	State of Mar		artment of F			Reg. No. () ()	25685
	Physici	an	Decedent's Name (First, Middle,	Last)		T	ODINE	2. Date of De. Month	Day Y	3. Time of Death
5	/Medio		4a. Facility Name (If not institution,	aive street and number)		4b. City, Town, o		08	13 20 4c. County of I	004 210 PM
	Examir	er	BAYVIEW MED		UTIONS	BALTI		411	40. Oddiny of 1	N/A
	Funeral			6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr		th 9.	Birthplace (State or Foreign Country)
	Director		214-46-2123	1€XM 2□ F	58 Yrs.	Months Days	Hours Mil			Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	to	Marriand	21++	,			T. A		1 ☐ Yes 2 1 No
	r 28a	rec	Maryland B 10e. Street and Number	altimore		10f. Zip Code		Edgemere	10g. Citizen of Wha	at Country?
	h with	al D	2903 Salisbur	y Avenue				21219	United	States
	ems ems	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No- irto Rican, etc.)	- 14. Race - A	American Indian, White, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 TxYes 2 □ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:	,	Specify:	
8	hour ntural	ed b	15. Decedent's	Year or Dates:	Vietnam	dent's Usual Occup	ation		16b. Kind of Busin	White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23a or 28a-f show he Madical Exami her multice multied at	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give	kind of work done of the NOT use retired	during most of w	orking	TOD. KING OF BUSIN	essilidustry
212	d with giene grene	mo:	12 Years	College (1-4or 5+)		Dispatch	er		Trucki	ng Company
nd	a! Hy d other	Be C	17. Father's Name (First, Middle, La	ist)			18. Mother's Na	ame (First, Middle,	Maiden Surname)	
<u>ya</u>	outd to Ment arkec	To	William Louel	·				Mary Vavı		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the multibuter all ADGS.		19a. Informant's Name/Relationshi Misty Peters /			-			er, City or Town, Sta	_{ite, Zip Code)} Maryland 21222
	s 1 and 2 of Health a itam 27 Is		20a. Method of Disposition	- Daughte	20b. Place of Dispo		TEGIOV	Date L	20c. Location - City	
Baltimore,	ages int of t: If it		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Spe	Removal from State	cemetery, crer	natory or other place			Middle H	
Ħ	artme ortani injury		21. Signature of Funeral Service Li							
Ba	Depar Impor any ir		Vent a	~					Dundalk, Maryland 2	
			23a Fart1. Enter the disease or conshock, or heart failure. List of	omplications that caused th	e death. Do not ent	er the mode of dyin	ng, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between
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_	be sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a o	consequence of):					
In	and and II-tran	хап	that initiated events resulting in death) Last	c	consequence of):					
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9	death certificate be executed e attending physician and id for use as the burial-transi	edic		0.						
Вох	death certifica attending ph d for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2 [Cotonio progonale			23d. Date of	delivery
B.	the atte	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tim]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year
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orc	v requir been si should	eted	ATRIA	FIBRIL	LATION			1 1	'es 2 □ No 3 □	Probably 4 Unknown
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₹	siciar certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 CER/Outrotion	Othe		ath (Check only or	-/-	
Division of Vital Records,	Attending Physician: or death. actor: After this certifics by the funeral director, I	-	27. Manner of Death	1 Impatient 28a. Date of Injury	28b. Time of	t 3 DOA 28c. Injun	4 🗀 Nursing		ence 6 Other (5	Specify)
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Vis	or Attendater deatl	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be ed 28e. Place of Injury building, etc. (- At home, farm, stre	eet, factory, office		28f. Location (S. City or Town		r Rural Route Number,
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	To the Hospital or At within 24 hours after d To the Funaral Diract completely filled in by	edical	(Check only 2 Medical E)	Physician: To the best of reaminer: On the basis of ex	my knowledge, death camination and/or inv	occurred at the time	ne, date and plac	e, and due to the c	ause(s) and manner	r as stated.
	To the He within 24 To the Fe	Med	one) 29b. Signature and title of certifier	and manner stated	d.	29c. License				
	7 × 100		NA. Q. O	- Wan P.				1	29d. Date signed (M	
,	11		30. Name and address of person wi	no completed cause of door	th (Item 23a) (Type				00 1121 0	7007
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	Sta	te		Registrar's			• • • • • • • • • • • • • • • • • • • •			
	Registr	ar	AUG 1 7 20	U4 Meserca	N. 693					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BALDWIN FREDERICK AUGUST 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Baltimore Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days, Hours | Min. (Month, Day, 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 214-46-8009 56 Yrs Director Feb.15,1948 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Maryland Baltimore Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3517 Milford Mill Road 21244 items 23a United States 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other than "natural", or items 23 12. Was Decedent Ever in U.S.
Armed Forces?

1 월 Yes 2 □ No 1968·
If Yes, Give
Year or Dates: 1969 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Atlantic Lift College (1-4or 5+) Technical Communicator Truck, Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick William Baldwin, Jr. Doris Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dale Baldwin (Wife) 3517 Milford Mill Road, Windsor, MD 21244 item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
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any injury or ott | Community of Disposition | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | Community of College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plants | College Plan * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Rd., Randallstown, MD 21133-4784 elluer M60333 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DEMENTIA disease or condition resulting in death) ADVANCED /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, igne 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 20 No 1 Tyes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 NInpatient 2 ER/Outpatient 3 DOA Onte of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident Injury 5 Pending after death. Director: A 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Functional (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

PITAL

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

CINTEN

29c. License number

D 0141410

JOGINDER P MEHTA RANDAUSTOWN MO

29d. Date signed (Month, Day, Year)

August

State of Ma Department of Health and Mental Hygiene

							Ce	rtificate d	of Dea	th		Reg. No. 0) 4	25687
	Physicia /Medica	n	Decedent's Name (First,	Middle, La		Nettie	E. B1	ades			2. Date of De Month	Dey	Year 200	3. Time of Death
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-			LORIEN (C 5. Social Security Number	(1) K	IVERSI	de ln yrs.	lest hirthday	If Under 1 Ye	ear If Un	ellA ider 24 Hrs.	M Date of Bir	HAR	FOR	Diece (State or Foreign
L	Funeral Director	-	219-10-5607 Usuel Residence of Deced	1	□ м Ж Т	90	Yrs.	Months Da		rs Min.	Aug 19	1913	MAry	yland
	a-f show		10a. State 10b. 0	County N/A			y,TownorLo Baltim						1	0d. Inside City Limits XXXX Yes 2 ☐ No
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מכח	is a	by Fur	11. Marital Status 1 □ Never Married 2[**XX Widowed 4 □ Di	☐ Married	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Yeer or Da	ent Ever in U ces? 2 1 1 10		Was Decedent If Yes, specify (1 ☐ Yes 2 ☒	Suban, Mex	rican, Puerti	pecify Yes or No o Rican, etc.)	Blad	e-Americ ck, White, v:Whit	etc.
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)	Vithi Com		29b. Signature and title of	certifier	1 M	luro	m	29c. Lic	anse numb)1_ eu		29d. Date signed	d (Month, I	Day, Year)
1	B		30. Neme and address of p	erson who	completed cause	of deeth (Item	23a) (Type,	Print) Inc	re Pl	rel/	rel Bre	l Du	pm	22014
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year E. Katherine **Blymire** August 16 2004 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗙 F Director 215-42-8847 59 June 2, 1945 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itame 23a or 28a-f show other treumatic event, the Mcdical Examiner must be notified at Directo 1 XYes 2 No Maryland n/a **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Itame 23a 4414 Falls Road 21211 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No 3 ☐ Widowed 4 M Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 09 n/a Clerk Liquor Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I Charles Bosley, Sr. Isabelle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) pormit Pages 1 and 2
Department of Health an.
Important: If item 27 is m.
any injury or other Patricia A. Lacey/Daughter 20226 Middletown Road, Freeland, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 8/19/04 1 XBurial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) 2 Funeral Service Vice Service Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Bryan W. 23a. Part1. Enjor tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) **Physician** Renal Fall /Medical Due to (or as a consequence of). Examiner betes 1a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien hed for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Š as been signed I 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ brillation 1 XYes 2 □ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: After this certification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 No Director: 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Direct completely filled in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 061886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) seriamin MI 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 7 2004

			1 - For State Registrar	State of M	larylan	•	artmer			and M	lental H	ygier Reg. N	0.0	0.1.	256	20
	Physici	an	Decedent's Name (First, Middle, La.	•		_					2. Date of D Month		ay	Yeer	3. Time of	
4	/Media	al		James Ed		Burl	41	*			Augus)ay	2004	5:15	P. M
	Examir	er	4a. Fecility Name (If not institution, giv 4203 Doris Ave)				Location of	of Death		4	ic. County			
	Funeral		5. Social Security Number 6. S		ge (In yrs.	last birthday)	If Under	r 1 Year	If Under		8. Date of B	irth			ace (State o	r Foreign
	Director		214 18 6862	⊠ M 2□F	81	Yrs.	Months	Days	Hours	Min.	Nov • 2	25, rea			yland	
	pu *		Usuel Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							11	od. Inside Ci	by Limits
	Maryli f sho	ō	Maryland N/A			altimo								1.	1 <u>X</u> Yes	
	128a	Director	10e. Street and Number			ar ornio	10f. Zip	Code				10g. C	Citizen of	What Coun	try?	
	23e o	al D	4203 Doris Aven	ue				2122	25				U.S	•		
	ems ermi	Funeral	11. Marital Status	12. Was Decedent Armed Forces		S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or N Rican, etc.)	lo-		e - Americ		-
36	s afte	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give	WW I		1 🗆 Yes		Specify:					. Whi		
21215-0036	i within 72 hours after death with the Maryland liene. I than "natural", or Items 23e or 28a-1 show The Medical Examinar must be notified at	edt	15. Decedent's E	Year or Dates:		16a. Dece	dent's Usu	al Occupa	ation			16b	l	usiness/Inc		
215	within 72 ene. then "ne	plet	(Specify only highest gra	de completed) Cotlege (1-4or	5+)	(Give	kind of wo DO NOT u	rk done d	lurina mos	t of worki	ng	100.			,	
21	filed with Hygiene. Ither ther	Completed	8th			Sh	ip Fi	itter						ehem :	Steel	
pug	ed la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last,						18. Mothe		(First, Middi			ne)		
Maryland	d 2 should be th and Mental 7 is marked o traumatic eve	ဥ	Edward 19a. Informant's Name/Relationship (10b Mailie	a Addense	/Stmata	and Alumba		othea :			Canan Zin	Codel	
Ma	12 h a 7 m		Veronica Burl	/ wife		4203										
ē,	Hear Hear Hear Hear Hear Hear Hear Hear		20a. Method of Disposition			lace of Dispo	sition (Nar	ne of			ate Date	ore, Maryland 21225 20c. Location - City or Town, State				
E										3/13/	2004	G1	en Bu	rnie	Mary	land
Baltimore,	permit. Pag Department Importent: I eny Injury c		1 ØBunal 2 Cremation 3 Removat from State 1 Donation 5 Other (Specify) Clen Haven Mem. Park 8/13/2004 Glen Burnie, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A.													
111	80539		21. Signature of Europea Service Licensee													
	Physician		23a. Part1. Enter the disease, communication of the shock, or heart failure. List only timmediate Cause (Finat	one cause on each	tine.	to Tic	er the mod	le of dying	such as	Cardiac	r respiratory	arrest,			Approximate Interval Bety Onset and D	veen
	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as	s a conseq	uence of):	- 12	0 - 1	9	01	L	7			Zana	0.7
		20	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	ali g	Mana	11	tell 1	al	et.	Juni	m			0110	05
	uted I Insit	Examiner	Cause (Disease or injury	M	alig	3man	1	asi	itis						Im	W
oʻ	sician and burial-transit		that initiated events resulting in death) Last	Due to (or as	a conseq	uence ot):										
68760	2 0	icai	(_d												
39 ×	leath certifical attending phy I for use as th	Physician/Med	IF FEMALE:	00- 11	4											
Вох	attenc for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. It yes, outcome 1 Live birth 4 Pregnant a	2 Feta	Ideath 3	Ectopic pr						23d. Dai Mo	te of deliver Inth	-	ear
o.	at the de by the a tached	ysic	1 Yes 2 No 9 Unknown	9□ Unknown	it time or di	oatii J	J Ollier (Sp	ocity)								
<u>α</u>	gned be de	þ	Part II. Other significant conditions of	contributing to death	but not resi	ulting in the u	nderlying c	ause give	n in Part I.						cause of de	
To the second se																
Records,	The law sate has page 2 s	Completed						· ·				s an opsy ormed?	/	Were autop prior to com death?	sy findings a pletion of ca	vailable use of
Vital		e Cc	25. Was case reterred to medical						26 Place	of Dooth	1 ☐ Yes (Check only			I ☐ Yes :	2□ No	
>	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitat:	ent 2 🗆	ER/Outpatien	t 3 DC	Othe	_		ne 5 Res		6 □Oth	er (Specify	1	
n of	ding Ph h. After th funeral		27. Manner of Death 1 Najural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of	2	8c. Injury Work			28d. Describe					
Sio	at at a	cati	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗆 Y	es 2 🗆 1	No						
Division	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of in	ijury - At ho tc. (Specify	ome, tarm, str v)	eet, factory	, office		4	28t. Location City or To	(Street a wn, Sta	and Numb te)	er or Rural	Route Numb	oer,
_	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier 1 Certifying Ph	lysician: To the best	of my kno	wledge, death	occurred	al the tim	e, date an	d place.	and due to the	cause/	s) and ma	nner as sta	ted.	
	n 24 t n 24 t he Fu	Medical	(Check only 2 Medical Examone)	miner: On the basis of and manner s	of examinat	tion and/or in	estigation.	, in my op	inion, deal	th occurre	ed at the time	, date a	nd place,	and due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				290	: License	number			29d. D	ate signed	(Month, D	ay, Year)	
7			P 911	uem	. D.			+	544	13			8/	11/0	4	
By,			30. Name and address of person who	completed cause of	0 11	23a) (Type, O. NO V&	-	st.	Ва	lti	more		MD	212	225	
	Sta		31. Date filed (Month, Day, Year)	- 6.	rar's Signa	ture	1									
	Registi	ai 🥫	AUG 1 7 200	4 June		10	4000	de								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

		State of Maryland / Department of Health and N		
		AMEND TIEM #20b PER FH G834 8/17/GELTIFICATE of Death 1. Decedent's Name (First, Middle, Last)	Reg. No.	3. Time of Death
н	Physician	PAULINE E. BAIN	Month Day Year	
	/Medical Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		18.30hrs
1	Examiner	HAMILTON GENESIS ELDERCARE BALTIE	MOREI	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	(Month, Day, Year) . Co.	pplace (State or Foreign untry)
	Director	Usual Residence of Decedent		an ada WI
	lend	10a. State 10b. County 10c. City, Town or Location		10d. tnside City Limits
	Mary Mary Tor	MD Essex		1XYes 2□ No
	death with the Maryland one 23a or 28a-f show cross to notified at neral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Co	untry?
	23a c	1220 S. Mar / AVE 21221	U.S.F	ł.,
		11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Amer Black, White	
36		1 Never Married 20 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:	Specify: (2)	cod
5-0036	led within 72 hours s lygiena. Ner than "natural", o nt, tre Medical Exar Completed by	15. Decedent's Education 16e. Decedent's Usual Occupation	16b. Kind of Business/I	ndustry
215	hin 72 In "nat Medic	(Specify only highest grade completed) (Give kind of work done during most of work. Elementary/Secondary (0·12) College (1·4or 5+)	ing	
2121	ed withing of withing of them.	15 years NUISE	1-105pi	+ 41
pu	be filed tel Hygie d other event, to		e (First, Middle, Maiden Surname)	
yla	should be and Mantel or marked or urmatic eve	UN KNOWN LYRI	s A. Bain	
Maryland	d2 st th enc 7 is n traun	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		1221
	ges 1 end 2 should be filed within 72 hc 1 of Health end Mantel Hygiena. If Itam 27 is marked other than "natun or other traumatic event, the Medical To Be Completed	20a Method & Disposition 20b. Place of Disposition (Name of	Ave MD 2 Date 20c. Location - City or 1	
Baltimore,	Pages ient of nt: If It ry or o	1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) SACRED HEART	3-17-64 Dunde	IK MD.
ati	글 본론를 .		201100	100
ä	Depe Impo	22. Name and Address of Facility Wastey Chavis 5 2007 Easter W	Ave Balto MD	11731
		23a. Part. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.		Approximate
	Physician	Shock, of heart failure clist only one cause on each line.		triterval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition a Metry starte Grantine	ancer	
		Due to (or as a consequence of):		
Т	executed in end inel-trensit	b. Itnaemia		
,	ifficete be executed g physician end as the bunel-trensit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):	- 1	
68760,	g physician as the buriel	Cause (Disease or injury that initiated events Due to (or as a consequence of):	y for	
	ng ph as t	resulting in death) Last	ch obstructu	
Вох	The law requiras that tha daath certificate has been signed by the attending page 2 should be datached for use as Completed by Physician/Me	d		
	the a	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t.	23b. Did tobacco use contribute	to the cause of death?
P.0	ad by datac		1 ☐ Yes 2 ☐ No 3 ☐ Pro	obably 4⊡t/nknown
ds,	sign d be		24a. Was en autopsy 24b. V	Vere autopsy findings
00	h requirements should be s		performed? a	vailable prior to ompletion of cause f death?
Re	he law a has b aga 2 s			☐Yes 2☐No
ital	entificat sctor, p	25. Was case referred to medical 26. Place of Death	n (Check only one)	
1	hysici his cer il direc	examiner? 1 Yes 2 No Hospitat: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Spec	ify)
0	fter th Inera	1 ⊡Natural 5 □ Pending (Month, Day Year) Injury Work?	28d. Describe how injury occurred	
sio	tendl leath. Ior: A tha fu	2 Accident investigation 3 Suicide 6 Could not be 389 Place of Injury. At home form street factory office.		
Division of Vital Records,	or At effar of Direct in by	4 ☐ Homicide 3 ☐ Solidar Title of determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	 Location (Street and Number or Ru- City or Town, State) 	ral Houte Number,
	ours ours filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) and manner as	stated
	To the Hospital or Attanding Physician: The law within 24 hours effar death. To the Funeral Director: After this certificata has completely filled in by the funeral director, page 2. Medical Certification: To Be Compl	(Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred end manner stated.	ed at the time, date and plece, end due	to the cause(s)
	Withir Comp	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month	, Day, Year)
		D31464	B/12/	04
	8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 100 000	riman -
		SHUALIS A. HASHMI MD, 821 N. EUTAN ST	SINTE SOX, ISAL	MD 21201
	State Registrar	31. Date filed (Month, Day, Year) AUG 1 7 2004 32. Registrar's Signature		
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	0.			Registrar 1. Decedent's Name	e (First, Middle	. Last)				inout	011	Journ		2. Date of D		0:	Lip	3. Time	of Death
_	п	Physicia		Ronald		And	rew			Cotti	cill			Month Augus	_	ay 14	Year 2004	7:15	p M
		/Medic Examin		4a. Facility Name (/	f not institution					4b. City	, Town, or	r Location	of Death	Titagas			y of Death	1/ 6.1.5	
			<u>.</u>	Rolling	Mill Ro	ad and Ca	ntan Ce	enter l	Drive		Colga	ate				Bal	timor	re	
		Funeral		5. Social Security N		6. Sex 1] X] M 2□		(In yrs. las		If Unde Months	r 1 Year Days	if Under Hours	24 Hrs. Min.	8. Date of B (Month, L	irth ay, Yea	SCE	9. Birth	place (State ntry)	or Foreign
		Director		217-74-6			<u> </u>	3	8 Yrs.					uctober	8, 13	965	GA.		
		land ow		10a. State	10b. County			10c. City,	Town or Lo	cation								10d. Inside (City Limits
		Mary s-f sh	to	Ohio	Sciot	0		Wes	t Por	tsmo	uth							1 🗌 Ye	s 2 🔀 No
		th the	Director	10e. Street and Nu	mber				-		p Code	•	<u>.</u>		1		What Cou	ntry?	
		2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or liems 23e or 28e-f show teamked other then "naturel", or liems 15e or 28e-f show remaits event, Its Muulcal Examiner must be multied at		2213 Ros	e Avenu					45	663					USA			
		r dea	Funeral	11. Marital Status		Ame	Decedent E		13.	Was Dece If Yes, spe	dent of H ocify Cuba	ispanic Or an, Mexica	rigin? (Sp in, Puerto	ecify Yes or N Rican, etc.)	10-		ce - Ameri ack, White,		
	36	rs afte	by F	1 Never Marr		lf Yes	es 2 DNo , Give or Dates:	0		1 🗆 Yes	2 X No	Specify:	r:			Speci	^{tγ:} Whi	te	
	8	2 hour			15. Decedent	's Education			16a. Dece	dent's Usu	al Occup	ation			16b.	Kind of E	Business/Ir	ndustry	
	215	hin 72	Completed	(Spec		t grade complet	red) ge (1-4or 5+	+)	(Give life.	DO NOT	ork done o use retired	during mos d)	st of worl	ang	11.01		G-1		
	21	er the	Com	12 years					Mov	ver							y Comp	pany	
	pu	be file tal Hy d oth	Be	17. Father's Name							İ			ө (First, Midd	le, Maide	en Suma	me)		
	yla		은	Alvin E					401-14-15		. (011			Lee	h 0'h	T		- (- 1-)	
	Baltimore, Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 le marke other treumatic		19a. Informant's N			wif	6		•				a <i>i Route Num</i> Ports				45663	Į.
	Ġ,	1 and 2 Health Iem 27 I	18	20a. Method of Dis		L ±	WILL	20b. Pla	ce of Dispo	sition (Na	me of	1		Date	-		- City or T		
	no	Pages nent of I nnt: If ite		1 🔀 Burial 2		3 □Removal fo	rom State	1	netery, crei dens (Cem.		ist 18, 2004	Ro	പ്പെട	ale,M)	
/	Hir	artn orte inju	1	21. Signature of Fu				1	n 2	2. Name a	nd Addre	ss of Facili	lity						
	ñ	Departiment of the particular	}	VIII	hory	('. (on	nel	ly S	ionne 7110	Soli	runer ers F	cal l	Iome Of Road,	Dur Dur	ida ik ida ik	Md.	21222) •
				23a. Pert1. Enter t shock, or hea	the disease, or	complications the	nat caused to	the death.										Approxima Interval Be	atween
		Priysician	2.0	Immediate Cause disease or condition	(Final	L	100	TPU		MU								Onset and	Death
•	1	/Medical Examiner		resulting in death)		Due Due	e to (or as a												
		Lxaiiiiiei	L	Sequentially list co	onditions,	b	(_		
		ed tsit	xaminer	if any, leading to in cause. Enter Under Cause (Disease or	nmediate eriving injury	e Du	e to (or as a	conseque	ince or):										
		xecuted and al-transit		that initiated event resulting in death)	S	c. Due	e to (or as a	conseque	ence of):								_		
	09,	eath certificate be e. attending physician for use as the buria	alE																
	89	ificate g phy as the	edic				251113123												
	ŏ	h cert endin use	N/M	IF FEMALE: 23b. Was deceder			, outcome o			⊒Ectopic p	regnancy	,					ate of deliv		
	œ.	deat	sicla	in the past 12	□No	4 □ P	regnant at t			Other (s						М	lonth	Day	Year
	P.C	that the death	Physiclan/Medical	9 Unknown				A A 16				an in Daw		22e Die	Laborer	2.1160.666	atributa ta 1	the cause of	doath?
	Division of Vital Records, P.O. Box 68760	es peq	b	Part II. Other signi	meant condition	ons contributing	to death bu	it not result	ung m me u	inderlying	cause giv	en in Part	1.		Yes	2 100		bably 4	
	Ö	w requir been s should	Completed													1045	1044		
	Rec	has l	ldm											per	opsy formed?	,	prior to co death?	opsy finding ompletion of	cause of
	a	icien: The l certificate ha rector, page	e Co	25. Was case refe	rrad to madical							OC Disc	a of Dog	1 X Yes		No	Yes	2 □ No	
	S	Physicien: this certificatal director, is	0 8	examiner? 1 ✓ Yes 2 □		Hospital:	1 🗌 Inpatier	nt 2∏E	R/Outpatie	nt 3□ D	Oth	000		ome 5 ☐ Re		6 V. t	her (Speci	fu) =+ c	cene
	10	g Phye er this eral di	F.	27. Manner of Dea	th	28a. C	Date of Injury Month, Day	v 2	28b. Time o		28c. Injur Wor	y at		28d. Describe	e how in	jury occu	rred		scene
	ior	Attending I r death. ector: After by the funer	Certification:	1 Datural 2 Accident	5 Pendin	gation 3 -	14-06		7:01	₽M	1 🗆	Yes 2	No	PASSE	ewgo	en o	= 401	2 61	ECTEV
	ivis	l or Attendater death Director:	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be lined 28e. F	Place of Inju	ry - At hom . (Specify)	ne, farm, st	reet, facto	ry, office			28f. Location City or T	(Street own, Sta	and Num ate)	ber or Rur	al Route Nu	mber, M
	0	urs after rel Dir						D D L	-					Round	MIL	ROB	IND CV71	word	wern
		Hospital Pours Funerel tely filled	Medical	29a. Certifier (Check only	1 Certifyir	ig Physician: T Examiner: On t	o the best o he basis of mannar stat	examination	dedge, deat on and/or in	th occurre vestigatio	d at the tir n, in my o	ne, date a pinion, de	ind place ath occur	, and due to th rred at the time	e cause e, date a	(s) and m ind place	anner as s , and due t	stated. o the cause	(s)
		the the	Med	29b. Signature and	d title of certifie		h			29	c. Licens	e number			29d. D	Date sign	ed (Month,	Day, Year)	
		To To		Mai	Ma T	- 11	e M	all 1			0.	C.M.E	Ξ.		Aug	gust	15,	2004	
	/			30. Name and add	ress of person	who completed	cause of de	eath (Item :	23a) (Type.	. Print)									
	D					ell M.D.		-			n St	reet	, Ba	ltimore	, Ma	aryla	and 2	1201	
			ate	31. Date filed (Moi			32. Registra	-	ıre							_			
		Regist	rar		AUG 1	7 2004	Ben	م جسامه ب		1	soul	1/2/							

			For 1 _ State	State of I	Maryland	_	artment of H			lental Hyg	giene	/D/C.	
			Registrar 1. Decedent's Name (First, Middle	la (ast)		Ce	rtificate of I	Death		2. Date of Dea	leg. No.	114	25693 3. Time of Death
п	° Physici	_	RUSSOIL	,,	Ca	in				Month	Day	Year 2004	AZ 5 M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and numb		411	4b. City, Town, or	r Location of	of Death	Hugust	-	ty of Death	0510
*	Exq. III.		Johns Hookins i	Bayview M	edical a	enter	P	alti	mo	re			
-	. Funeral		5. Social Security Number		Age (In yrs. las		If Under 1 Year Months Days	If Under Hours		8. Date of Birth (Month, De) Mar 8,	Year)	Cour	lace (State or Foreign
	Director		442-32-0350 Usual Residence of Decedent	1 X M 2 □ F	70	Yrs.				Mar 8,	1934	0kla	hóma
	land		10a. State 10b. County	,	10c. City,	Town or Lo	ocation					1	0d. Inside City Limits
	Mary Fied	ţ	MD Balt	timore		Dunda	1k						1 ☐ Yes 2 No
	h the	irec	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cour	ntry?
	hours after death with the Maryland tural', or Itams 23c or 28a-1 show al Examinar must be notified at	Funeral Director	7232 German Hi	111 Road			2	1222			U	SA	
	r dea	ner	11. Marital Status	12. Was Decede Armed Force		13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori an, Mexicar	igin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ace - Americack, White,	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 【XDivorced	If Yes, Give			1 ☐ Yes 2 🎇 No	Specify:			Speci		ite
21215-0036	a within 72 hours after death with the Marylan Jene. r than "natural", or itams 23c or 28a-1 show It e Medical Examinet must be notified at	edb		Year or Date		16a Dece	dent's Usual Occup	ation			16b. Kind of I		
215	within 72 ene, than "nat	Completed		est grade completed) College (1-4		(Give	kind of work done of DO NOT use retired	durina mos	it of worki	ing	100.11.10		303 ll y
21	d withir giene. er than	Com	11	0	51 54)		disal	oled				none	
	be filled ital Hygie of other evant, It	Be (17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,		ıme)	
yla		^L	Louis Cain								upe		
Maryland		6 9	19a. Informant's Name/Relations William Cain/s				ng Address (Street A						Code)
	1 and 2 Health tam 27 othar tr		20a. Method of Disposition	5011	20b. Pla		sition (Name of	venue		Date	20c. Location	1222	own State
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or othar to		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 📉 Other (S	3 Removal from Sta	ate cen	netery, crei	matory`or other plac	(8)		1	2001 200411011	ony or re	, Gallo
alti.	permit. F Departme Importan any injur		21. Signature of Funeral Service	icensee	//	2:	2. Name and Addres	ss of Facili	ty	-			
ä	Depa Impo any ir once		Louis	S. Wade, Di	recor	St	tate Anat	omy B MD	oard 2120	655 W.	Baltin	nore S	treet
3			23a. Part . Enter the disease, or shock or heart failure. List	r complications that cau t only one cause on eac	sed the death.						est,		Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition	RESP	PIRAT	OR	Y FAIL	URC	-				Onset and Death
Ш	/Medical Examiner		resulting in death)	Dye to (or	as a conseque	nce of):							
и	-	<u></u>	Sequentially list conditions,	b. PME/	AS a conseque	nce of):							
	ned Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 DIA	31-50		FUTU						
Ć,	sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	as a conseque	nce of):		<u>۔۔۔۔۔</u>					
8760	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai		Ld. HYD	ERTE.	NS/	X						
9	ntifica ing ph s as th	Med	IF FEMALE:	7.									
Вох	leath certifica attending pt d for use as th	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal d	eath 3	Ectopic pregnancy	,				ate of delive	nry Day Year
0	he de the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐Unknow	t at time of dea n	th 5	Other (specify)					iona i	Suy Tour
٥.	that the died by the detached		Part II. Other significant conditi	ions contributing to deat	h but not result	ing in the u	nderlying cause give	en in Part I		23e. Did to	bacco use cor	ntribute to th	e cause of death?
Vital Records,	quires in signe	d by								1 □ Y	es 2□No	3 Prob	ably 4 Unknown
000	aw requir as been si 2 should l	ompleted								24a. Was a		. Were auto	psy findings available
Re	The lay ate has page 2	E O				-				autop: perfor	Sy	prior to cor death?	npletion of cause of
ita	iclan: Th certificate rector, pag	BeC	25. Was case referred to medica examiner?	al		_		26. Place	of Death	Check on or		12.00	
of V	Physician: this certific ral director,	P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp		R/Outpatier		4 L NU	ursing Ho	me 5 🗆 Resid	ence 6 □Ot	her (Specify	1)
ou c	ling After Tune	ion	27. Manner of Death 1 □ Natural 5 □ Pendir		njury 2 Day Year) 2	8b. Time o Injury	Worl		_	28d. Describe h	ow injury occu	rred	
Division	att :: e	icat	3 ☐ Suicide 6 ☐ Could		Injury - At hom	e farm st	M 1 [Yes 2 🛭		28f Location /S	troot and Num	har or Pura	I Route Number.
Div	al or Attano after death Director: d in by the I	Certification:	4 Homicide determ	building	etc. (Specify)	o, laini, sti	eet, factory, office			City or Tow	n, State)	Der or Hura	r noute Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the		29a. Certifier 1 Certifyii	ng Physician: To the be	est of my knowl	edge, deat	h occurred at the tin	ne, date an	nd place, a	and due to the c	ause(s) and m	nanner as st	ated.
	ha Ho in 24 ha Fu pletel	edical	(Check only 2 Medical one)	Examiner: On the basi and manner	s of examinatio	n and/or in	vestigation, in my o	pinion, dea	ith occurr	ed at the time, d	ate and place	, and due to	the cause(s)
	To T To T	Σ	29b. Signature and title of certifie	er 2			29c. License	e number	,	2	9d. Date sign	ed (Month,	Day, Year)
•			Devinde	e 12 Stoler	a H	12	D2,	1/8	8_		8/4/0	4	
			30. Name and address of person	who completed cause	of death (Item 2	(Type,	Print	Dr.		A 10	x 2	222	
	Sta	ate	31. Date filed (Month, Day, Year,) 32. Reg	istrar's Signatur	re -9	1144	V W	weel.	1-11	<u> </u>	2-2	
1/5	Regist		AUG 1 7 28	104 Sept	pa of	4	Sports						

	. Decedent's Name (First, Middle, I			artment of 1834 8726/0 ortificate of		2. Date of Deat	2.75	11.33	3. Time of Death
Physician /Medical	Concetta (Comeaux				AUGUST	Day 2	Year	1:22 PM
	a. Facility Name (If not institution, g		2:-	4b. City, Town, o	r Location of Death	,	4c. County	of Death	
5	00.	Sex 7. Age	(In yrs. last birthday	BALT If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	150	O Birthr	olego (State or Foreign
	215–16–1383	1 □ M 21 7. Age	84 Yrs.	Months Days	Hours Min.	Dec. 26	, 1919	Mary	olece (State or Foreign ntry) y Land
2 >	Usual Residence of Decedent Oa. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show times the motified at 1 mast learned line of 1	Maryland N/A		Balti	more					XX Yes 2 □ No
Sometiment of the Market of th	0e. Street and Number			10f. Zip Code		10	Og. Citizen of		ntry?
s 23a	1. Marital Status	Apt. 326			.239	acifu Vas ar Na	14 Ra	USA	can Indian,
S after de rittern de	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√ TxN	lo	Was Decedent of H		Rican, etc.)	Bla	ck, White,	
215-0036 uthin 72 hours after e. Madical Examens	3 €XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes ≱(¬¬¬¬¬No	Specify:		Specif	WII-	ite
21215-00 ed within 72 hou goglene. It, the Medical Ed., the Completed	15. Decedent's (Specify only highest of	grade completed)	(Giv	edent's Usual Occup e <i>kind of work done i</i> DO NOT use retired	ation during most of work d)	king	16b. Kind of B	usiness/In	dustry
d 2121 d 2121 filed within Hygiene. sther then " e Comple	Elementary/Secondary (0-12) unknown	College (1-4or 5		visor Sea	mstress	N	Mens C1	othir	ng Mfgr
lid be fill be	7. Father's Name <i>(First, Middle, L</i> a John Palmasino	st)			Agata I	Ragonese			
ore, Mary es 1 and 2 shou of Health and W filem 27 is mar r other freumat	19a. Informant's Name/Relationship Agatha Jones	(Type, Print) (Niece)	1 7912	A Westmor	and Number or Rui	ral Route Number,			
S. 1 and Health item 2 other 2	20a. Method of Disposition		20b. Place of Disp				Ltimore 20c. Location		
Page:	X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Special Control C		Dulaney	Valley Me Jardens	morial 8/	/17/04 (Cockeys	ville	e, MD
	21. Signale Funeral Service Lie	agentin	- É	2. Name and Addre urgee—Hen 631 Falls	ss of Facility ISS-Seitz Road Ba	Funeral	Home. MD 21	Inc. 211	
Dissolution	23a Part 1. Enter the disease, or co shock, or hear failure. List on Immediate Cause (Final disease or condition	mplications that caused ly one dause on each lin		nter the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
	resulting in death)	- a.	a consequence of):	1500	- CA		C		
5 8	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence of):	- H5AF	7 1 1	LUF		-	
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6 5 5 S 2	F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		☐Ectopic pregnancy	,			te of delive	•
S, P.O. Be es that the death igned by the atterbed for by Physicial	in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown		Other (specify)			M	onth	Day Year
dS, P.(iries that the signed by doe detact d by Phy	Part II. Other significent conditions	s contributing to death bu	ut not resulting in the	underlying cause giv	ren in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
Cords **require been sig should b						1 □ Ye	s 2 No	3 🗌 Prob	pably 4 Unknown
Division of Vital Records, for a transfer death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by						24a. Was ar autops	/	prior to cor	psy findings available mptetion of cause of
Vital Rec sicien: The law s certificate has t lirector, page 2 s	75 184					perform 1 ☐ Yes 2	⊠ No	death? 1 🗌 Yes	2 ☑ No
Of Vita Physicien: this certific	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Minpatie	nt 2 ER/Outpatie	ent 3 DOA Oth	or	th <i>(Check only one</i> ome 5 🗆 Reside		er (Specifi	v)
on of Vital Reding Physicien: The In. After this certificate ha funeral director, page	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Time Injury	of 28c, Injur Wor	y at k?	28d. Describe ho			
isio ttendi death. stor: A / the fu	2 Accident investigat 3 Suicide 6 Could not	be Ose Blace of Iniv	ıry - At home, farm, s		Yes 2 □ No	28f Location (Str	oot and Numb	or or Rum	J Route Number,
Division cell tall or Attending Person after death. el Director: After led in by the funers Certification:	4 Homicide determine	building, etc	e. (Specify)	treet, ractory, onice		City or Town	, State)	er or Hura	I Houte Number,
72 7 2 2	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best of aminar: On the basis of and manner sta	examination and/or i	th occurred at the tir nvestigation, in my o	me, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and ma	anner as st and due to	ated. the cause(s)
To the within To the complex Me	29b. Signature and title of certifier	. 0		29c. Licens			d. Date signe		
	* Kakush N	nallic 1	ムカ	1285	5000	A	ug ust	14	- 2004
	30. Name and address of person when the second seco	no completed cause of de	CODO S	AMARIT	AN HUS	PITAL.	BALT	IMU	RE, MD.
State State	31. Date filed (Month, Day, Year) AUG 1 7 2004		ur's Signature		()				

2004

AUGUST 12,

JAMES COURY

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Cassid rands 08 2001 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner N.E. New Jersey Ave. Burnie Glen Hnne Arunde If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex **Funeral** Days Hours 1₩ 2□F PA 71 Yrs 197-26-0436 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatic executions. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count 1 ☐ Yes 2 ☐ No Director MD Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 U.S.A. 315 New Jersey Avenue N.E. Completed by Funeral 12. Was Decedent Ever in U.S. Agned Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc Armed Forces? 1 ATYes 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Appliance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Cassidy Anna Martin ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Alberta Wiggington/partner 315 New Jersey Avenue N.E., Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Cremation Aug 14,2004 Stevensville, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Licensee art le Moi357 | Second Avenue S.W., Glen Burnie, MD 21061 23a. Part1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Nonsmall ceil lung cancer 11 mos disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): ettending physicien a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1XYes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of After Hospital or Attending 5 Pending 1 Natural 2 Accident 2 🗌 No death. investigation efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely (Check only one) and manner stated. To the 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier 8-11-04 D0059173 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd, Suite 300, Annapolis, MD 21401 7 900 Kemmer 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG11 77 2004

ORIGINAL

			For State Registrar	State of Maryland		artment of tificate of		Reg	200	25697
\$. T	Physici	20	Decedent's Name (First, Middle, Last,					2. Date of Death Month	Day Ye	3. Time of Death
	/Medi		Carlos	Cruz				August	12 200	4 6:36 A ^M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Deat	h	4c. County of I	Death
			Washington Advent	ist Hospital		Tako	oma Park		Montg	omery
4	Funeral Director		(Unavailable)	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, You May 14,	9. 2003 1	Birthplace (State or Foreign Country) Maryland
and	ž		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Lo	cation				10d. Inside City Limits
he Maryl	23s or 28s-f show	Director	Maryland Prince G	-		Hyatts	ville			1 □ Yes 2 No
death with the Maryland	23a or 2 unt be n	rai Dir	10e. Street and Number 1409 Merrimac Dr.	#102		10f. Zip Code	20783	-	Citizen of Wha	•
9	or Ite	by Funeral	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cub X Yes 2☐ No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - / Black, V Specify:	American Indian, Vhite, etc. White
2 5	ie. Naviral Ex.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. l	lent's Usual Occu kind of work done DO NOT use retire	pation during most of wor ad)	king 161	o. Kind of Busine	ess/Industry
	al Hygiene. I other than vent, the wa	Co	0		N/A				N/A	
Maryland	and Mental Hy Is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Jose	Cruz			18. Mother's Nan August	ne (First, Middle, Mai Lina	,	(Unavailable)
and	and Is me		19a. Informant's Name/Relationship (Ty	эө, Print)	19b. Mailin	g Address (Stree	t and Number or Ru	ral Route Number, C	ity or Town, Stat	e, Zip Code)
, N	n 27 er tr		Michelle Boudrye				11ow Rd.,	Highland	MD 20	777-9766
Baltimore,	nt: If iten		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State	netery, cren	sition (Name of natory or other pla eaven Cen	· A	ug. 14,	Silver	or Town, State
Balti permit.	Department of Health a Importent: If item 27 Is any injury or other tra		21. Signature of Funeral Service Press		22 R	Name and Address App Fune	ral and C	remation S	Services	1
97/	17-00	-	23a. Part1. Enter the disease, or compli	cations that caused the death.	Do not ente	or the mode of dvi	no. such as cardiac	or respiratory arrest	g, MD	20910 Approximate
7	nysician Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	rond		syndro			Interval Between Onset and Death
pe	xaminer ্ট্ৰ	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		nce of j.					
x 68760, certificate be execut	physician and the burial-transit	icai Examin	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):					
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ecords, P.O law requires that the	8 8	by	Part II. Other significant conditions con	tributing to death but not result	ing in the un	derlying cause gr	ven in Part I.	23e. Did tobaco	Y	o to the cause of death?
Ö D	beer	ete						-		
<u>م</u> ۽	ate has page 2	Completed						24a. Was an autopsy performed	? prior death	
of Vital Physician: T	this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				th (Check only one)		
Phys.	this al dir	2	/ 31.63 2 110	I □ Inpatient 2 x at	R/Outpatient	OL DOX		ome 5 Residence		pecify)
on guilt	After Aune	Certification;	27. Manner of Death Satural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Inju Wo M 1	ryat rk? Yes 2 □ No	28d. Describe how in	njury occurred	
DIVI:	rs after d sal Direct led in by	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Street City or Town, St	and Number or ate)	Rural Route Number,
] the Hospitel	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tile estigation, in my o	me, date and place, opinion, death occur	and due to the cause red at the time, date	o(s) and manner and place, and c	as stated. ue to the cause(s)
Tott	with To t	Σ	29b. Sign to e and title of certifier	ghtfert h.	M.P	29c. Licens	se number	29d.	Date signed (Mo	
\			30. Name and address of person who co James K. Lightfoot				ve., Takon	na Park. M	D 20912	2
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	a /	akst				

		•	For State Registrar	State of M	aryland			of Health of Deat		lental Hy	gien Reg. N	2001	25698
P	Physici		1. Decedent's Name (First, Middle, Roslyn	Last)			Dix	n		2. Date of D Month	1 0	yea Yea	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, STAR JOHNS HO	Kins No	SOITA	t birthday)	Bn/+		or 24 Hrs.	B Date of B	irth	N/A 9. B	intholece /State or Foreign
	Funeral Director		UNKNOWN Usual Residence of Decedent	1□M 2 X F	4		Months D	ays Hours	Min.	APRIL	5 ,	1963 MA	RYLAND
	Maryland a-f show	tor	10a. State 10b. County MD N/A		10c. City, 1	Town or Loc	cation						10d. Inside City Limits 1 ▼Yes 2 □ No
	or 282	Direc	10e. Street and Number	_			10f. Zip Co	de				Citizen of What	Country?
0.0	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or itema 23e or 28e-f show event, the Modical Examinational be notified at	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		If	21202 Vas Decedenti Yes, specify	Cuban, Mexic	an, Puerto	ecify Yes or N Rican, etc.)	U.S	14. Race - An Black, Wi	nerican Indian, nite, etc.
5-0036	2 hours a aturel', c	ted by	3 X Widowed 4 □ Divorced 15. Decedent's	Year or Dates:		16a. Deced	ent's Usual C			ina	16b.	Specify: Kind of Busines	BLACK ss/Industry
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Mary	and 2		19a. Informant's Name/Relationship KENNETH PURNELL									or Town, State YLAND 2	
altimore,	Pages 1 ar		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3		cem	netery, crem	sition (Name of attory or other	r place)		Cate		Location - City o	or Town, State , MARYLAND
Baltin	permit. Pages Department of Important: If it any injury or of		4 □ Donation 5 □ Other (Special Service Line)		GREE	22	. Name and A	ddress of Fac	cility CA	LVIN B	SC	RUGGS F	UNERAL HOME RYLAND 21213
4	Physician		23a. Pert1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition	ily one cause on each t	d the death ine.		er the mode o		as cardiac (or respiratory	arrest,		Approximate Interval Between Onset and Death
隻	/Medical Examiner		resulting in death)	Due to (or as	a conseque		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						6 hours
- N.E	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque		NEWM OF	nia			-		One week
3760,	ate be executed hysician and the burial-transit	cal	resulting in death) Last	Due to (or as	a consequer	nce of):		nuy 5	Joha	re_			Three years
.O. Box 68	ath certific ittending p or use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	eath 3 🗆	Ectopic pregr					23d. Date of d Month	lelivery Day Year
ds, P.	uires that the de n signed by the a id be detached i	by	Part II. Other significant condition Reval failure	s contributing to death t	out not resulti	ing in the ur	nderlying caus	e given in Pai	t I.				to the cause of death? Probably 4 Munknown
Records,	The law requirate has been sipage 2 should la	Completed								24a. Wa auto peri 1 🗆 Yes	opsy formed?	prior to death	autopsy findings available occumpletion of cause of ?
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Othor		(Check only			
Division of Vital	Attending Phyaician: r death. ector: After this certifics by the funeral director, I	tlon: To	1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju	iry 2	NOutpatien 8b. Time of Injury		Injury at Work?		me 5 ☐ Res 28d. Describe		6 ☐Other (Sp jury occurred	oecify)
Divisi	or afte in	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of In	jury - At homitc. (Specify)	e, farm, stre	eet, factory, or	fice		28f. Location City or To	(Street a	and Number or late)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical		Physician: To the best caminer: On the basis of and manner st	of examination								
	To the within To the complex	Me	29b. Signature and title of certifier	Medid	Doch	_	-	cense numbe			A	ate signed (Mo.	
			30. Name and address of person		4	3a) (Type, I	D -0					ust 14,	
7			John Nguyen, The	Johns libekins	Hospita	1,600	North 1	UHE ST	reet,	Baltimore	-, Ma	inyland	21287
4	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	rar's Signatur	Se Se	park	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 17,2004 **Physician** Year Mildred Devore 1:20 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TxF 249-74-5021 62 Yrs. Director Jan.4,1942 South Carolina Usuat Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "netural", or Items 23a or 28a-f show ury or other traumatic event, Ita M. Alce Exp. illust ... and be notified at 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Completed by Funeral Director 1XYes 2 □ No Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3019 Otter Square 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 25No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Macfarland T. Devore Elizabeth Johnson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leila Devore-Sharpe / Daughter 3019 Otter Square, Waldorf, MD 20602 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Importent: If any injury or once. Riverdale Pk. Crematory 7/28/04 *4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Latney's Funeral Home Mary 3831 Georgia Ave., NW, Washington, DC 20011 averne 23a. Part1. Enter the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Sepis disease or condition resulting in death) MAK-OW7 /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events Due to (or as a consequence of) Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 2 - No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Rota Faraham M.D D43446 7.17.04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avesnit 3-41 S. low spring MD

State Registrar RUINTAN FARAHIFAR

AUG 1 7 2004

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

M.D

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yeer 12, John J. Mq Downes Aua. 2004 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Cromwell Towson Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 4, 1920 **Funeral** Birthplace (State or Foreign Çountry) 1**⊠**M 2□ F 84 Months 231-16-1007 Çounti Va Director Usuel Residence of Decedent with the Maryland 10a. State r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Md. Director Baltimore Dundalk 1 ☐ Yes 2 1 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2630 Plainfield Rd. 21222 USA death v 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be lifled within 72 h
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natu
any injury or other treumatic event, I're Medical
ance. 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Service Station 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John E. Downes Blanche May Burkholder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sam Wickline brother-in-law 550 Dundalk Ave. Balto. Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Aug 1 2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 17, Oak Lawn Cem Baltimore * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Connelly Funeral Home Of Dundalk

//110 Sollers point Rd. 21222 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MON MO /Medical Due to (or as a conse where of): Examiner Sequentially list conditions, it any, is along to immodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medicai as the l IF FEMALE: esn nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 2 1 Inpatient 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e s of person who ompleted cause of death (Item 23a) (Type, Print) 3 MCDAS Month, Day, Year, 32. Registrar's Signature State Registrar

			. For	State of Maryla	and / Depa	artment of H	lealth and		ene on o	25701				
			1 - State Registrar		Cei	rtificate of	Death		g. No UU4	20/01				
	Dhusisi		1. Decedent's Name (First, Middle, Last,)				Date of Death Month	Day Yeer	3. Time of Death				
150	Physici /Medic	_	Stephen Drombosl	ĸi				08	08 2000	835 AM				
	Examin	1	4a. Fecility Name (If not institution, give	street and number)			or Location of Dea	th	4c. County of Dea	ath				
2-4			Union Memorial 1	Hospital			imore							
	Funeral Director		1/3-10-3828	X M 2□F 7. Age (In y 85	rs. last birthday) Yrs.	Months Days	Hours Min		^{9. Bi} 1918 Nev	rthplece (State or Foreign country) W Jersey				
	pu *		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits				
	anyla shor	_	MD 100. County		Baltimo					112 Yes 2 No				
	Ne M	Director			Dartimo					41				
	with the	Dic	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?				
	death with the Maryland ms 23a or 28a-f show rmat be notified at	Funeral	2700 N. Charles S			2121			USA					
	item item	nu	11. Marital Status	12. Was Decedent Ever in Armed Forces?	10.5.	If Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi					
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 X Yes 2 ∏ No If Yes, Give Year or Dates: 142	_/, 5	1 ☐ Yes 2 🎇 No	Specify:		Specify: W	nite				
21215-0036	within 72 hours after ene. then "natural", or ite he Modical Examina	ed	15. Decedent's Edu			dent's Usual Occup	pation	1	6b. Kind of Business					
5	in 72	Completed	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most of we	orking		sylndustry unk				
7	with liene	Eo	Elementary/Secondary (0-12)	College (1-4or 5+)		mechani	С							
D	i Hygir other	BeC	17. Father's Name (First, Middle, Last)		,		18. Mother's Na	ime (First, Middle, M	aiden Sumame)					
a	lid be lental ked c	ToB	Joseph F. Drombos	ki			Rose	K. Koleza	c					
Maryland	should be and Mental s marked o umatic sve	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Street	and Number or R	lural Route Number,	City or Town, State,	Zip Code)				
	tra tra	١.	Union Memorial H	ospital	201	E. Univer	sityPkwy	Baltimro	e, MD 21	218				
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition		b. Place of Dispo	sition (Name of	1			r Town, State				
Ë	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 14 ② Donation 5 ☐ Other (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,								
三	permit. Departm Importa any inju		Surgest Computer											
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100			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused the d				c or respiratory arre	st,	Approximate Interval Between				
美	Physician		Immediate Cause (Final		Onset and Death									
*	/Medical		disease or condition resulting in death) a. ASPIRATION PROMONIQ Due to (or as a consequence of):											
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ó	an ar		resulting in death) Last	Due to (or as a cons	sequence of):					1				
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68	that the death certificate ed by the attending phys detached for use as the	by Physician/Medl	IE EEN ALE.						-					
Вох	th certification in the second	2	23b. was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregnanc	v		23d. Date of de					
ω.	death	sicie	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time o		Other (specify)	,		Month	Day Year				
P.O.	at the by th	hy	9 Unknown											
	S 5 0	by (Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.			o the cause of death?				
pro	w require been sig should to	ted						1 U Yes	s 2 □ No 3 □ P	robably 4 Unknown				
ပို	e lawr has be je 2 sh	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of				
8		OIL						perform	ed? death? ⊋No 1 ☐ Yes	_				
ita	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only one)					
of Vital Records,	8 w 5	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatier		4 🗀 Nursing	Home 5□Resider	nce 6 □Other (Spe	ecify)				
ם	ding Phy th. After thi funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	ry at rk?	28d. Describe how	v injury occurred								
<u>S</u> .	Attanding r death. ector: After by the fune	catl	2 Accident investigation			M 1 🗆	Yes 2 □ No							
Division	l or Attsnu after deatl Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	'ural Route Number,				
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	To the within 2. To the I complet	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)				
	->-0		1 553	Co M-D	,	050	0293		08,08,	2004				
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Type.									
			Benjamin C	ompleted cause of death (un, u	NISN M	emorial	Hospital	Baltima	re, Mariland				
F	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	non VI								
	Regist	ar	AUG 1 7 2004	portages.	14	o cours								

State Registrar

31. Date filed (Month, Day, Year) AUG 1 7 2004

BLUCLAH 32. Registrar's Signature

Tolyillah Ah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

August 12, 2004

		1	For State Registrar	State of Ma	ryland /		irtment of I tificate of			giene Reg. No: () (25703
			Decedent's Name (First, Middle, Last,						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia		Robert Wi	lliam	Duncar	1				14, 200		10:05 Mm
	/Medic Examin		4e. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Deati	n	4c. Count	of Death	
			Genesis Eldercar	e Hamilton	Cente	er		timore		n,		
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last b		If Under 1 Year Months Days		(Month, Da	y, Year)	Cou	
	Director		ZIO ET OILO	JM 201	80	Yrs.			February	17, 1924	Penns	ylvania
	pur *	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Aanyl raho	ō	MD n/a		Bal-	timor	9					1√ Yes 2 No
	28a-	ect	10e. Street and Number			-	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	with 3a or	Funeral Director	5501 Carter Avenue				21214			USA		
	death ms 2:	lera	11. Marital Status	12. Was Decedent E	ver in U.S.	13.	Was Decedent of	Hispanic Origin? (S	pecify Yes or No		ce - Ameri	can Indian,
60	or Item	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 XNo If Yes, Give	0		1 Tes, specily Cui 1 ☐ Yes 2 🕱 No	oan, Mexican, Puer Specify:	o mean, etc.)	Speci		ite
Ö	ral', c	by	3 Widowed 4 Divorced	Year or Dates:			103 204110	opoury.				
5	72 hours atter death with the Maryland natural; or Items 23a or 28a-1 ahow disal Examinar must be notified a	Completed	15. Decedent's Edi (Specify only highest grad	ication le completed)	16	(Give	dent's Usual Occu kind of work done	during most of wo	rking	16b. Kind of E	Business/Ir	ndustry
21	within ene. than "	Jdu	Elementary/Secondary (0-12)	College (1-4or 5+	-)		DO NOT use retire y boy	9 <i>a)</i>		Sun News	naner	
7	e filed within al Hygiene. other than '		17. Father's Name (First, Middle, Last)	n/a		ωμ	у ооу	18 Mother's Na	me (First, Middle			
and	ould be fi Mental H arked ot atic ever	Be		t inaan				Mabel	Elizabe		rvine	
2	should be nd Mental s marked umatic ev	2	Walter M. [uncan	15	9b. Mailir	na Address (Stree	at and Number or Ri				p Code)
Maryland 21215-0036	d 2 T is		Betsy Garner-niece	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				enue, Balti		21214		
	1 an Heal tem 2		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other pl		Date	20c. Location	- City or T	own, State
2	ages ant of tt: If it y or c		1 Burial 2 Cremation 3 .		1		vice Corp.		/04	Towson,	MD	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Icens				2. Name and Add	. =	eonard J.			aral Home
B	Depariment of the post of the		11111	WITTIGHT	. Dau	5	305 Harfor	d Rd. Bali			· Turk	i ai noic
	-,		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death. D	o not en	er the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as a		-						
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	ecute ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	4mc	na a4\;	ofth	X			-	
90,	e executan a		resulting in deathy cast	T.	Consequent	20 OI).	bla-l	So			1	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Physician/Medical	•	d	n V V	V	- 40	our				
9 x	eath certific attending p I for use as I	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					23d D	ate of deliv	verv
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetel dea		☐Ectopic pregnan☐ Other (specify)	су			lonth	Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown								- James V
٥.	es that the de igned by the a be detached i	y P	Part II. Other significant conditions of	ontributing to death bu	ıt not resultin	g in the t	inderlying cause g	given in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
Records,	puires n sign ald be	d by	mental	Ketand	atus				1 🗆	Yes 2□No	3 ☐ Pro	bably 4 Unknown
00	w requii	Completed							24a. Was		. Were aut	opsy findings available ompletion of cause of
Re	The lav	E O							perf	ormed?	death?	2□ No
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<u>></u>	Physician: this certificantal director,	To B	examiner?	Hospital: 1 Inpatie	nt 2 ER/	Outpatie	nt 3 DOA	other: 4 Nursing	Home 5 ☐ Res	idence 6 🗆 O	ther (Spec	sity)
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	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner sta			29c. Lice	nse number		29d. Date sign	ed (Month	n, Day, Year)
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			30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type	. Print)	- 1		1	-	4 MY 21201
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Year Nancy Ann Dewese 2004 Aug. 14, 10:50 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 29), 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M **3**□ F Maryland Director 212-58-3631 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits "neturel", or items 23a or 28e-f show discal Examiner must be ovtified at 1 ☐ Yes 2☐No Completed by Funeral Director Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 313 Orchard Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes **¾**☐ No If Yes, Give Year or Dates: Specify: white 1 ☐ Yes 2 INO Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) H & M Wagner Customer service rep. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Holloway James Pennington ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 313 Orchard Rd. Glen Burnie, MD 21061 Carlis J. Dewese Sr. husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory Aug. 17, 04 Baltimore, MD ^¹ 4 □ Donation J 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service L 3620 Wilkens Ave. Baltimore, MD 21229 Page . Enter the disease, or complications that called the shock, or heart failure. List only one cause of the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. Approximate Interval Between Onset and Death Immediate Cause (Final intraabdominal Carcinomatosis **Physician** disease or condition resulting in death) MOS. /Medical Due to (or as a consequence of): Examiner oveast caucer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown sate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other. Certification; To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical сотрівтелу 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fifte of certifier 29c. License number 29d. Datę signęd (Month, Day, Year) 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestyair Rd. Annapolis, Md. Selovich, MU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2004

			State of Ma	-	partment of lertificate of	Health and M Death		ene 2004	25705
	Physici /Medic Examir	al	4a. Facility Name (If not institution, give street and number)		7ANS 4b. City, Town, o	or Location of Death	2. Date of Death Month AUGUST	Day 14 2004 4c. County of Death BALTIMO	3. Time of Death 2:02 AM
	Funeral Director		GILCREST HOSPICE CENTS 5. Social Security Number 216-34-4255 Usual Residence of Decedent	ER e (In yrs. last birthda 68 ^{Yrs.}	Months Davs		8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	olace (State or Foreign ntry) RYLAND
	the Maryland 28a-f show notified at	rector	10a. State 10b. County MD BALTIMORE 10e. Street and Number	10c. City, Town or WIN		ILL	100	. Citizen of What Cour	10d. Inside City Limits 1 □ Yes 2 No
36	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f show the Madical Examirer must be mutified at	Completed by Funeral Director	3115 RIPPLE ROAD 11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced 12. Was Decedent & Armed Forces? 1 Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No	21244 Hispanic Origin? (Specian, Mexican, Puerto F	cify Yes or No- Rican, etc.)	USA 14. Race - Americ Black, White, Specify: BI	
121215-0036	iled within 72 hou lygiene."nature ther then "nature nt, ine Madical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH 17. Father's Name (First, Middle, Last)	16a. De	e. DO NOT use retire	during most of working d)	ng		
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Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Madical Examination will be multipled at 2008.		IRIS H. EVANS / WIFE 20a. Method of Disposition 1	20b. Place of Dis cemetery, of	15 RIPPL: sposition (Name of crematory or other pla CREMATO	RY 8/1	ate 20 5 / 0 4	ILL, MD 2 c. Location - City or To	own, State E, MD
Ba	eded of the state		234 Gas. Enter the skease, or complications that caused shock, or heart allure. List only one cause on each lin lmmetriate/Cause Final		4600 LI	BERTY HGI	HTS AV,	BALTIMO	OME 21207 RE, MD Approximate Interval Between Onset and Death
8760,	/Medical Examiner physicien and the priral-transit the priral-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease of ilipiny that initiated events c.	a consequence of): a consequence of): a consequence of):					
Box 6	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of delive Month	ery Day Year
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1			30. Name and address of person who completed cause of de AARON CHARLES WW C	eria Sianatura	Charles	ST BE	1tours	e me Z	1204
	Sta Regist		AUG 1 7 2004	ar's Signature	Sporks				

Frans, Junson 8-14-04 03-03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2/Pate of Death Decedent's N Pirst, Middle, Last Month Year **Physician** 2001 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deet Examiner Baltimore 7300 Chesapeake Drive Sparrows Point If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 15.1914 1 ☐ M 2 □XF 89 Yrs. VA. 217-16-0831 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23s or 28s-1 show the Medical Exemprer must be notified at 1 ☐ Yes 2 XNo Funeral Director Sparrows Point MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21219 7300 Chesapeake Avenue 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home **HOusewife** 12 years othert traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fillent of Health and Mental Hynt: If item 27 Is marked oth y or other traumatic event Be Margaret Bailey Irwin G. Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7300 Chesapeake Drive, Sparrows Point, MD. 21219 Irwin J. Heinle Sr. Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 August 18 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: If eny injury or once. Mearbwridge Memorial Park Elkridge, MD. 2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Connelly Funeral Mome Of Dundalk, P.A. 21. Signature of Funeral Service Licensee 7110 Sollers Point Road, Dundalk, Md. 23a. Part! Enter the disease or complications that shock, or heart failure. List only one cause of not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Theet and Death aused the death. Immediate Cause (Final disease or condition resulting in death) **Physician** mich /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnat 3 □Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No the detached 9 Unknown 9 TUnknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but in tresulting in the underlying cause given in Part I. ģ ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No 4 🗆 Nursing Home 5 Residence 6 □Other (Specify) 2 1 Tes this nerel Director: After th 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 24 hours a 29a Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signe Month, Day, Year 29c. License number 29b. Signature and title f certifier 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

Payleut uncun ac: Rivka Edelstein Ballimara Marvland 21215-0036

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	Funeral		5. Social Security Number 6. 5	Sex 7. Age	(In yrs. last birt	hday) If Under	1 Year If Under 24 Hrs	8. Date of Birth	9 Bir	A thplace (State or Foreign
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	nyland how		10a. State 10b. County		10c. City, Town			· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	the Ma	Director	MD BALTIMOR	₹E	BALTIM	ORE 10f. Zip	Code	110	Og. Citizen of What Co	1 Tyes 2 No
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	r deatl	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Deced	ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
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212-0036	within 72 he ene. than "natu	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)			Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of wo	orking	16b. Kind of Business	/Industry
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and		Be	17. Father's Name (First, Middle, Last ISRAEL)	SMAD	τ¥	18. Mother's Na	me (First, Middle, λ ΤΝΛ		NOBTAINABLE
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Bartimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation X 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	CITY	F LOD CE	METERY 08/1		OD, ISRAEI	
Ball	permit. Pages Department of I Important: If its any injury or o		21. Signature of Funeral Service Lice	The Cutte	Pu		Address of Facility SC			
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Вох	death certificate t e attending physion of for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death				23d. Date of de Month	livery Day Year
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<u>≥</u>	s after al Dire	Certification;	4 Homicide determined	building, etc	c. (Specify)	, 5,1551, 145151,	, 55	City or Town	, State)	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funaral Director: After this certificate has been signed by thi completely filled in by the funeral director, page 2 should be detached.	Medical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination an	e, death occurred d/or investigation,	at the time, date and place in my opinion, death occ	e, and due to the ca surred at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To th To th	Ž	29b. Signature and title of certifier	10 - 10	1.0		License number		od. Date signed (Mon.	
			30. Name and address of person who	completed course of d	eath (Item 23e)	(Type Print)	PES-000	P	ugust 13,	2004
•	8		Juliannekenton	, MD. Si	rai Ho	spital	of Baltim	ore		
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Physicia /Medica Examine	al	4a. Facility Name (If not institution, give street and number)	EL S. EBRON, SR. 4b. City, Town, or Location of Death	gust	Day Year 3. Time of Death 1955	
Funeral Director		Univ. of Mb Medical Center 5. Social Security Number 6. Sex XXM 2 F 7. Age (In yrs. last birthde Yrs. Usual Residence of Decedent	Batimore y) If Under 1 Year If Under 24 Hrs. 8. D. (A) Months Days Hours Min. 0.3	ate of Birth Month, Day, Yea	9. Birthplace (State or Foreing Country) 48 MD	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, it e Madical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or MD NA Baltime 10e. Street and Number 4615 Park Heights Ave 11. Marital Status 12. Was Decedent Ever in U.S. 1	ore 10f. Zip Code 21215		indian, load of the limit of th	
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age ento ento ry or		Nathaniel S. Ebron Jr. 6834		rkvill 20c.		
permit. Pe Departmen Important any Injury		23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		altimo piratory arrest,	Approximate Interval Between Onset and Death	
Medical Examiner and partial-transit	dical Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, large	5 · Mearitime			
certif nding use at	Physician/Med		3 Dectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
	Completed by Pt	Part II. Other significant conditions contributing to death but not resulting in the Acquired Immunodeficiency	Syndrome		o use contribute to the cause of death? 2 No 3 Probably 4 Unkno 24b. Were autopsy findings availa	
hysician: The his certificate hi il director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 FR/Outpat 27. Manner of Death 1 Matural 5 Pending (Month, Day Year)	26. Place of Death /Che tient 3 DOA Cther: 4 Nursing Home of 28c. Injury at 28d. I		prior to completion of cause of death? No 1 Yes 2 10	
en a sign	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office 28f. L	City or Town, Sta	,	
To the Hosp within 24 hou To the Fune completely file	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	29c. License number	the time, date a	Date signed (Month, Day, Year)	
3+1 Stat Registra		30. Name and address of person who completed cause of death (Item 23a) (Typ. VATNIEEN F. IDEN NAN MP 22 SN 31. Date filed (Month, Day, Year) 32. Registrar's Signature	P16469 mm Greene Street Ball	firmare,	MD 21201	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death S. Time of Death 1. Decedent's Name (First, Middle, Last) AÜĞÜST 12, 2004 **Physician** 7:45 A M FREEDMAN SIDNEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE OWINGS MILLS ATRIUM VILLAGE ASSISTED LIVING Birthplace (State or Foreign Country) 8. Date of Birth Month, Bay, Year) JULY 25, 1910 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F Months MD 94 215-07-6301 **Director** Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or itams 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director OWINGS MILLS MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 USA 4730 ATRIUM COURT #478 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify: Specify: þ 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREEDMAN SELIG ANNIE UNOBTAINABLE ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12305 SILVER CUP COURT - REISTERSTOWN, MD 21136 JILL KATZ / GRANDDAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State ò 4 ☐ Donation 5 ☐ Other (Specify) MIKRO KODESH BETH ISRAEL 8/15/04 BALTIMORE, MD injury 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Fyneral Service Licensee any in 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner The law requires that the death certificate ba executed burial-transit Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 🗌 Yes 2 25 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifier 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) MA Main 25 CIGEV 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item # 10g, 15 per Inf ,G836, 10/21/04 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Gerald Month Yea **Physician** nn 08 2004 115:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1108Otral MCRE (If Under 24 Hrs. 8. Date of Birth 11/28/1943 7. Age (In vs. last birthday) ocial Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 XXXVI 2□ F 60 CANADA 419-35-9096 Director Usual Residence of Decedent with the Maryland itam 27 ia marked other than "netural", or Itams 23e or 28e-f show other traumatic event, the Medical Exement must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes XX No VΑ ARLINGTON 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 901 NORTH NELSON STREET #1605 22203 -USA- Canada death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2001 Married ☐ Yes 2 Tho Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: WHITE <u>چ</u> 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: if it am 27 is marked other than any Injury or other traumatic access College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT RELATIONS PETROCHEMICAL 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MAXWELL FINN ٥ MARGARET HARPEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CANADA 21-1200 RIVERSIDE DRIVE, LONDON, ONTARIO N6H5C6 MARY CATHERINE FINN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date UNK 20c. Location - City or Town, State CANADA LONDON, ONTARIO XXBurial 2 ☐ Cremation XX Removal from State 4 Donation 5 Other (Specify) ST. PETERS CREMATORY 21. Signaturi Frineral Service Lice in exercise KELLY GREGORY 22. Name and Address of Facility FINK FUNERAL HOME, PA FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 days **Physician** Maliguant brain neoplasm /Medical Due to (or as a consequence of): Examiner Intracramal hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certiticate be executed burial-transit herniation Cerchival and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 ician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the detached Physi 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed?
1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? has 2 No 1 Yes To the Hospitel or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: № Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this tuneral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: in by the 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) atter 4 Momicide within 24 hours a To the Funaral L Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Res -000 August 11, ho completed cause of death (Item 23a) (Type, Print) Wolfe St. Balting ore, HD 212 600 N 32. Registrar's Signature State Registrar

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		_	State Registrar			rtificate of L	Death	Reg. M	2001	25711
H	Physicia /Medic		1. Decedent's Name (First, Middle, Las Richard Gilliss	')			À		6 200	3. Time of Death 4 2=30 A M
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	Funeral Director		5. Social Security Number 217–18–3309	X 7. Agi	9 (In yrs. last birthday, 80 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea Aug. 31,	1923 M	rthplace <i>(State or Foreigi</i> ountry) [aryland
	ը ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L.	ocation				10d. Inside City Limits
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	or 28a	Direc	10e. Street and Number			10f. Zip Code		10g. (Citizen of What C	ountry?
	ath w	ral	2207 Gaylawn Dr			21227			U. S. A	
2	72 hours after death with the Maryland natural; or tems 23a or 28a-f show ited Examiner must be natified at	by Funeral Director	11. Marital Status 1 □ Never Married	12. Was Decedent Armed Forces? 1 Xes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	ispanic Origin? (Speci in, Mexican, Puerto Ri Specify:	ry Yes or No- ican, etc.)	14. Race - Am Black, Whi	ite, etc.
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<u>a</u>		0.0	John Gilliss				Edna Mar	ctin		
Maryland	s 1 and 2 should be f Health and Mental item 27 Is marked o other traumatic eve		19a. Informant's Name/Relationship (7 Ellen P. Gillis			ing Address (Street a	and Number or Rural in Dr. Lans	Route Number, City Sdowne, M		
ře,	of Hea item		20a. Method of Disposition	D f Chh-	20b. Place of Disp	osition (Name of ematory or other place	Da Da	te 20c.	Location - City or	r Town, State
Baltimore,	permit. Pages 1 and Department of Healtl Important: If item 2? any injury or other t		1 XBurial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify)			ial Park 8		Elkridge	, MD
gail	Depart Depart Import any in		21. Signature of Funeral Service Licen	See .	100		ss of Facility Ineral Home			21227
9	Physician /Medical Examiner		23a Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. End St	the Swith. Do not en	iter the mode of dyin		respiratory arrest,	utus, Mi Dis a use	Approximate Interval Between Onset and Death
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Box 68760,	Attending Physician: The law requires that the death certificate be refeath. ector: After this certificate has been signed by the attending physici. by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	,		23d. Date of de	elivery Day Year
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ion o	nding Ph ath. r: After th: e funeral		27. Manner of Death 1 Patural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry Year) 28b. Time Injury	Wor	y at 28 k? Yes 2 □ No	3d. Describe how in	njury occurred	
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	ro the vithin o the comple	Me	29b. Signature and title of certifier			29c. Licens	e number	29d.	Date signed (Mor	nth, Day, Year)
)	->-0		BG	Fen	physicia	n Ds	72544	Au	916,	2004
4			30. Name and address of person who	completed cause of		- 1	+204, Ca	tonsuille	2, MD	21228
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	Physici		Decedent's Name (First, Middle, Last)					 Date of Death Month 	Day Yeer	3. Time of Death
	/Medic		James N	ichael Gallo	way			August	11,2004	0858AM
	Examir		4a. Facility Name (If not institution, give si				Location of Death	~	4c. County of Dee	
			3739 Lochearn Di			Loche			Baltimo	
	Funeral Director		5. Social Security Number 6. Sex 252-70-5594	7. Age (In yrs. 57	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 2	9. Bir 0,1946 G	thplece (State or Foreign ountry) eorgia
7	and and		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
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TAMES G	5 £	by Funeral Director	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 17 Yes 2 No If Yes, Give Year or Dates:		r Yes, specify Cuba I□ Yes 2∏ No	Specify:	Hican, etc.)	Black, Whi	White
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Altimore altimore	item of He		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		Date	20c. Location - City or	Town, State
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09280		fical Examiner	Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hyperten Sin	quence of):	ioscherol	ric Cardio	vascula	A Disease	Interval Between Onset and Death 5 y 200 S
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<u> </u>	The page	Co						perform	ned? death? No 1 ☐ Yes	2 No
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5	Physi this c	2	180 185 2010		ER/Outpatien		4 Nursing Ho		nce 6 Other (Spe	icify)
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į	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	edical Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office	1	City or Town	eet and Number or R., State)	irai Houte Number,
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		i i	20 Name and address of the Mil	D Deputy	= 22a) (T	19186	067	A	ugust 11, 2	004
	b		30. Name and address of person who cou	MD 6 Trim	ble H	MCT. Lu	there. lle	Maryla	and 2109	3
	Sta Regist		31. Date filed Month, Day, Year) AUG 1 7 2004	72. Registrar's Sign	ature	sparks		,		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:57 AM **Physician** House 12 2004 Ervin Gunther, Sr. /Medical James 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Baltimore Franklin Woods Center Rossville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 157M 2□ F Director 93 Sept. 28,1910 Maryland 220-01-1611 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Hygiene. other then "natural", or Items 23a or 28a-f show ont, the Madical Examiner man be notified at Middle River 1 ☐ Yes 2 ☑ No Maryland Baltimore Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21220 United States 618 Wampler Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2½ No Specify. Specify. 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steelworker 8 Years Steel Industry other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Health and Mental James Gunther Anna Schultz 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Cummins / Daughter 618 Wampler Road Middle River, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/13/2004 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Stage **Physician** Dement A ENG resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, Physician/Medical 98 attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. Pe 9☐ Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 1 Yes 2 No 1 Yes Division of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending investigation 1 Tyes 2 No death. M 2 Accident Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 8/12/04 D53462 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Glem Burnie, MD 21061 OAKWOOD Wa 1845 32. Registrar's lignature State

Registrar

			For Stele	State	of Marylar		artment of H			giene	001	25711.
			Registrar 1. Decedent's Name (First, Middle	, Last)				J 04.77	2. Date of Dea	ath		3. Time of Death
	Physicia		Evamae		W.	ŀ	lannah		August	14.		5:25 P M
	/Medic Examin		4a. Facility Name (If not institution,	give street and I		•	4b. City, Town, or	Location of Deat			. County of Dea	
			Manor Care R	uxton			Towson				Balti	more
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 □ X F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	y, Year)		rthplace (State or Foreign country)
	Director		216-18-4466	1 M 2 M		87 Yrs.			Dec. 2	8, 1	L916 I	Maryland
	land land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation	 				10d. Inside City Limits
	Marylan -f show lied at	ō	Maryland Baltim	nore		Timor	nium					1 ☐ Yes 2 💢 No
	r 28a	Directo	10e. Street and Number	101 6		1 111101	10f. Zip Code			10g. Cit	tizen of What C	country?
	death with the Maryland ims 23a or 28a-f show	ai D	631 West Timoni	um Road			21093			Į	J.S.A.	
	ams	Funerai	11. Marital Status	12. Was De	ecedent Ever in U Forces?		Was Decedent of Hi	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	-	14. Race - Am Black, Wh	
20	s afte	by FL	1 Never Married 2 Marri	ed 1 Tes	s 2 X No Give		1 ☐ Yes 2 ☑ No	Specify:			Specify:	
2-003p	be filed within 72 hours after death with the Marylan tall tygliene. Id other than "natural", or Itams 23a or 28a-1 show evant. It e Marical Examiner must be notified at		3 XWidowed 4 □ Divorced 15. Decedent		Dates:	163 Dagge	dent's Usual Occupa	ation		16h K	and of Puninger	White
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and	e filec Il Hyg otha /ant,	0	17. Father's Name (First, Middle, I	_ast)				18. Mother's Na	me (First, Middle,			
Jai		To B	Otto Wetz	:e1				Evamae	Car	rick	ζ	
Mar)	2 should be and Mental Is markad aumatic ev		19a. Informant's Name/Relationsh	iip (Type, Print)		19b. Mailir	ng Address (Street a	and Number or R	ural Route Numbe	er, City	or Town, State,	Zip Code)
≥``	ロモトコ		Kenneth W. Brana	men, Jr			West Timo	nium Roa				
9	ges 1 t of H lf Ital		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removal fro	m State	cemetery, crei	sition (Name of matory or other plac	1	Date		ocation - City o	
altimor	tant:		• 4 Donation 5 Other (Sp	pecify)	Mon		Memorial					
g	permit. Pages 1 am Department of Heali Important: If Itam 2 any injury or other once.		21. Signature of Fundral Services	Hagan		22	Name and Address 1050 Yorl		uck Tows Towson,			Home, Inc. 21204
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	it caused the deat	th. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,		Approximate Interval Between
- 70	Physician	d: /	Immediate Cause (Final disease or condition	5	TRO	KE						Onset and Death
	/Medical Examiner		resulting in death)	Due !	to (or as a conseq	quence of):						
	LXammo	<u></u>	Sequentially list conditions,	b	to (or as a conseq							
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gox	death centificate be executed e attending physician and id for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		Ectopic pregnancy			01	23d. Date of de	livery
	deat ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐No		gnant at time of c		Other (specify)				Month	Day Year
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<u>ທ</u> ົ	w requires that the de been signed by the s should be detached	þ	Part II. Other significant conditio	ns contributing to		_	nderlying cause give	en in Part I.				o the cause of death?
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Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			Othe		ath (Check only o			
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UIVISION	Attan deal actor	fica	3 ☐ Suicide 6 ☐ Could n	not be 28e. Pla	ice of Injury - At h	ome, farm, str	eet, lactory, office		28f. Location (S	Street an	nd Number or A	ural Route Number,
5	al or safter	Certification:	4 Homicide	bui	ilding, etc. (Specil	(y)			City or Tow	m, State)	
	To the Hospital or Attanding Phys within 24 hours attendeath. To the Funeral Director: Affer this completely filled in by the funeral directors.	Medicai (29a. Certifier 1 Certifying (Check only one)	exeminer: On the	the best of my know basis of examina anner stated.	owledge, death ation and/or in	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occu	e, and due to the durred at the time, d	cause(s)	and manner a d place, and du	s stated. e to the cause(s)
	Fo the within Fo the complex	Me	29b. Signature and title of certifier	- 1			29c. License			29d. Da	te signed (Mon	th, Day, Year)
	->-0		> ///	On ha	lim		2-0	00128	49	8	-15-	04
h			30. Name and address of person v	who completed ca	ause ol death (Iter	m 23a) (Type.	Print)	2 2			2 4 0	04
D	′		AH. GHIL.	AD1.1			OSLE	RDr.	10 WS	on	/ /7/	4204
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 20	104	, Registrar's Signa	ature	Son V					

	1 - State Registrar	(Certificate of Death	Mental Hygie Reg	0001	25715		
ician	Decedent's Name (First, Middle, Last, HELEN HOLL			AUGUST	11 2004	3. Time of Death 7:45 A M		
dica! niner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	<u> </u>		
	MILLENIUM - FRANKI 5. Social Security Number 6. Se		BALTIMORE day) If Under 1 Year If Under 24 Hrs.	9. Data of Righ	N/A	lace (State or Foreign		
al or	220-20-9868 1 M 201 94 Yrs. Months Days Hours Min. 01 03/1910 PEN							
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location		1	0d. Inside City Limits		
ctor	MD N/A	В	ALTIMORE CITY			1 Yes 2 No		
Funeral Director	10e. Street and Number 2723 FISK ROAD		10f. Zip Code 21225		. Citizen of What Cour	ntry?		
nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White,			
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: BLAC			
ted	15. Decedent's Edu (Specify only highest grad		ecedent's Usual Occupation Give kind of work done during most of won fie. DO NOT use retired)	ring 16	b. Kind of Business/Inc	dustry		
Completed	Elementary/Secondary (0-12)	College (1-40r 5+)	fie. DO NOT use retired) DOMESTIC		ELF-EMPLOY	ED		
Be Co				e (First, Middle, Mai				
ToB	WILLIE TUCKER		LOTTIE					
	19a. Informant's Name/Relationship (Ty GAYE MOORE / GRA		Mailing Address (Street and Number or Rul 9 24TH AVENUE, TEMP			Code)		
1	20a. Method of Disposition	20b. Place of D			c. Location - City or To	wn, State		
	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	MD VET C	CEM-CHELTANHAM 8/	9/04 CHI	ELTANHAM, I			
9300	21. Signature of Funeral/Service Licens	Chull A	22. Name and Address of FacilityHOW 4600 LIBERTY HEIGH			21207		
	23a. Part1. Enter the disease, or complete or heart failure. List only of	ications that caused the healh. Do no	t enter the mode of dying, such as cardiac			Approximate Interval Between		
	Immediate Cause (Final disease or condition	Munc	and I Julan	Lin		Onset and Death		
	resulting in death)	Due to (or as a consequence of)		λ.	-1			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of)	many cerrary	Dire	esc	p		
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of)				8		
caiE		1	•					
Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ny Day Year		
S	1 □ Yes 2 No 9 □ Unknown	9□ Unknown						
, ř		ntributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?		
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b				24a Wasan	24h Word autor	nev findings available		
ompieted by				24a. Was an autopsy performed	prior to cor death?	osy findings available npletion of cause of		
b	25. Was case referred to medical		0.6	autopsy performed 1 ☐ Yes 🚱	d? prior to cor death? No 1 ☐ Yes	npletion of cause of		
To Be Completed by	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp. 28a. Date of Injury 28b. Tin	atient 3 DOA Other: 4 Nursing Ho	autopsy performed 1 Yes 1 American Yes 1 American American Yes 1 A	prior to cordeath? No 1 Yes e 6 Other (Specify	npletion of cause of 2□ No		
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Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 200 27. Manger of Death 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide 4 Certifying Phy (Check only one)	28a. Date of Injury 28b. Tin Inju 28b. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	atient 3 DOA Other: Wursing Horner of Work? M 1 Yes 2 No death occurred at the time, date and place, or investigation, in my opinion, death occur	autopsy performed. 1 Yes 2 h (Check only one) me 5 Residence. 28d. Describe how in the cause of the cause	prior to cordeath? No 1 Yes e 6 Other (Specify injury occurred at and Number or Rural late) e(s) and manner as st. and place, and due to Date signed (Month, I	Pay, Year)		
edical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 2 2 27. Manger of Death 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 2 Medical Examined 29b. Signature and title of certifier	28a. Date of Injury 28b. Tin Inju 28b. Place of Injury - At home, farm building, etc. (Specify) sician: To the best of my knowledge, oner: On the basis of examination and/of and manner stated.	atient 3 DOA Other: Wursing Horner of Work? M 1 Yes 2 No death occurred at the time, date and place, or investigation, in my opinion, death occur	autopsy performed. 1 Yes 2 h (Check only one) me 5 Residence. 28d. Describe how in the cause of the cause	prior to cordeath? No 1 Yes e 6 Other (Specify injury occurred at and Number or Rural late) e(s) and manner as st. and place, and due to Date signed (Month, I	Pay, Year)		
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Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Ye	
/Medic		Reese Paul Haddaway, Sr.	O. T	Hugust	- 14200	-
Examin	er	Franklin Square Hospital 48.	City, Town, or Location of Deat	n ·	4c. County of E	imore
Funeral		5. Social Security Number 7 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
Director		219-16-5915	onths Days Hours Min.	8. Date of Birth (Month, Day, August 27	, 1923	ary Pand
*		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
d sho	tor	MD Baltimore Perry Hal				1 Tyes 2 No
23a or 28e-f show ust be notified at	Director		Of. Zip Code	10	g. Citizen of Wha	t Country?
23a o	al D	9003 Hedgerow Way	21236		USA	
90.00	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was	Decedent of Hispanic Origin? (S s, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
	by Ft	1 Never Married 2 Married 1 ▼Yes 2 No MM TT	Yes 2 No Specify:		Specify:	White
		15 Decedent's Education 16a Decedent	's Usual Occupation	1	16b. Kind of Busine	ess/Industry
Man	piet	(Specify only highest grade completed) (Give kind life. DO life. D	d of work done during most of wor NOT use retired)	rking		,
	Completed	12 n/a Engir	eering Supervisor		C & P Tele	ephone
availit, il g	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, N	,	
	ို	Reese Lyndale Haddaway	Elizabe			
treumetic event, I're M			ddress (Street and Number or Ru			re, Zip Code)
r other tr		20a. Method of Disposition 20b. Place of Disposition	Hedgerow Way, Balt		21236 20c. Location - City	or Town, State
injury or c		1 X Burial 2 □ Cremation 3 □ Removal from State 1 □ Cremation 5 □ Other (Specify) 1 □ Cremation 5 □ Other (Specify)		7/02	Parkvil ¹	lo MD
e)				32711		Funeral Home
ouc			5 Harford Rd., Bal			die at Tole
		23a. ant. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.				Approximate Interval Between
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al		resulting in death) Due to (or as a consequence of):				racy
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- 10	niner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	-000	S They	o \	
	Examine	that initiated events c. resulting in death) Last Due to (or as a consequence of):	PC6.	18/1/5/		
	cai	L d		Mr Will		
	edi			755		
	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ect	opic pregnancy	~ \	23d. Date of Month	delivery Day Year
	sici	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	her (specify)		Month	Day real
		Part II. Other significant conditions contributing to death but not resulting in the under	tving cause given in Part I	23e. Did tob	acco use contribut	e to the cause of death?
	d by	Conculopathy due to Commidir)	1 □ Ye	s 2 No 3	Probably 4 Unknown
l	iete	AVTIFICIAL HOUVE VALUE		24a. Was ar	24b. Were	autopsy findings available
1	Completed	HERVI OF AMOU FIRMILLATION		autopsy	prior led? deat	to completion of cause of h?
	(D)	25. Was case reerred to medical	26. Place of Dec	1 ☐ Yes 2, ath (Check only one		Yes 2□No
di actor	To B	examiner? 1 No 2 No Hospital: 1 Impatient 2 ER/Outpatient	Other: 4 Nursing H	Iome 5 Reside	nce 6 Other (5	Specify)
2		27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury 28b. Time of (Month, Day Year) Injury	28c. Injury at Work?	28d. Describe ho		10
	Certification;	2 Accident investigation 8/12/04 day time			nt (w.tnesse	
	irtii	determined 286. Place of Injury - At notine, farm, street,	Office Steps	28t. Location (Str.	eet and Number o	1406 York
	i Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or	_	Abstraca	Kam MD	herville,MD
form point from dupo	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occu	irred at the time, da	ite and place, and	
	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (M	onth, Day, Year)
		For I State MO	D005772	21 2	3/14/04	
17		30. Nam d address of person who completed cause of death (Item 23a) (Type, Prin	(t)			MD 21237

	1	State of Mary	yland		rtment o				Re	g. No. U) 4	25717
Physician	1	. Decedent's Name (First, Middle, Last) Iris L. Hofmann						4 N	ate of Deat Month	Day	Year	3. Time of Death
/Medical Examiner	r f	a. Facility Name (If not institution, give, street and number) St. ACINIS HEQ.) H.C.C.			4b. City, To	hm	ore	>	J	4c. County		lace (State or Foreign
Funeral Director		219-07-4714 1□ M 210x 8	in yrs. Ia	ast birthday) Yrs.	If Under 1 \ Months D		Under 2 lours	Min. Dec	pate of Birth Month, Day, C • 15 ,	^{Year)} 1920	North	Carolina
show		Sul State		, Town or Lo					-		10	0d. Inside City Limits 1 ☐ Yes 2 No
death with the Maryland rms 23a or 28a-f show rmust be notified at	Director	Maryland Baltimore 10e. Street and Number	we	st Hil	10f. Zip Co				1	0g. Citizen of		itry?
ss 23a must b		733 Charing Cross Road 11. Marital Status 12. Was Decedent Eve	er in U.S	S. 13.	Was Deceder If Yes, specify	229	anic Orig	in? (Specify	Yes or No-	14. Ra	S.A.	
b 2 €	by rur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No II Yes 2 ☑ Yes 3 ☒ Widowed 4 □ Divorced Year or Dates:			If Yes, specify		Mexican, Specify:	Puerto Rica	n, etc.)	Specil	fy: W	hite
Maryland 21215-0036 at 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 Is marked other than "natural", or reaumatic event, the Medical Enerth	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		(Give life.	dent's Usual (kind of work DO NOT use	done duri retired)	n ing most	of working		16b. Kind of B		dustry
d 21; filed wit Hygien ther thu	Con	12 17. Father's Name (First, Middle, Last)		Vice	Presid		B. Mother	r's Name (Fir	st, Middle, i	F I O L Maiden Suma		
/land	lo Be	Unknown Brown						allee .		01 T	21.1. 7	Codel
Mary d 2 sho th and 17 is m		19a. Informant's Name/Relationship (Type, Print) Linda Hofmann (Daughter)								r, City or Town		nd 21229
or Heal	1	20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ Removal from State	20b. P	lace of Dispo emetery, cre	osition (Name matory or oth	of er place)	1	Date		20c. Location	-	
altimore, mit. Pages 1 ar partment of Hea portent: if Item y injury or other		*4 □ Donation 5 □ Other (Specify) 21. Signature of Juneral Service Lice 198	Lo	2	ark Ce	-	J 1	8-18-2				Maryland
Dal Department on the partment of the partment		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	Li	ノ 110	630 Edr	nonds	son A	Ave Ca	tonsv:	onsvill ille, M	e, in Maryla	nc. and 21228
Physician and physician and physician and physician and s the burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Due to (or as a Due to (or as a d.	conseq	uence of):	otic	Con	rde	ovas	cul	y Bil	ense	Onset and Death 40 yeu
Box 6 Box 6 Box 6 attending for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	. 🗌 Feta	death 3	□Ectopic pre □ Other (spe						ate of delivi	ery Day Year
ds, P.O. uires that the d	þ	Part II. Other significant conditions contributing to death but De me n Li &	t not res	sulting in the	underlying ca	use given	in Part I			obacco use co ′es 2□No	ntribute to t	the cause of death?
	Completed								-	rmed? 2 No	prior to co death?	opsy findings available ompletion of cause of 2 No
n of n of ng Phys	ation; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day) 2 ☐ Accident investigation		ER/Outpation 28b. Time Injury	of 28	Other:	4 🗆 Nı	28d	5 🗆 Resid	dence 6 0		ify)
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injudently building, etc.	ry - At h . (Speci	iome, farm, s	street, factory,	office		28f	Location (S City or Tox		nber or Rur	al Route Number,
Hospite 24 hours Funera etely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner states.	examin	owledge, dea ation and/or	ath occurred a investigation,	t the time in my opi	, date ar nion, dea	nd place, and ath occurred	due to the at the time,	cause(s) and r date and place	manner as s e, and due f	stated. to the cause(s)
To the within To the compil	Me	29b. Signature and little of certifility	N	X)	29c.	License 0	0Z	731 Hogi	5 1	Jugu. Date sign	ned:(Month,	Soay, Year) OY
30		M. C. Frydent of	ath (Ite	m 23a) (Typ	e, Print)	Jan	231	Hopi	Fal	Bal	900	none; Me
Sta Registr		31. Date filed (Month, Day, Year) 32. Registra	Sign	D)	spork	مد		V				/

			1 - For State Registrar		State of M	arylaı	nd / Dep		t of H	ealth a		•		0.01	25	718
	Physic	ian	Decedent's Name (First, M.									2. Date of Dea Month	ath Day	/ Year		ne of Death
	/Medi		John Howa					1				August	12			:50A M
	Exami	ner	4a. Facility Name (If not institu		,			4b. City,	Town, or	Location of	Death		4c.	County of De	ath	
			Charlestow 5. Social Security Number	1 Care		io (In ure	. last birthday,			ville		0. 8-11-1/8:-		Baltim		
	Funeral Director	Н	210-05-4260		M 2□F	89.	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Nov. 6	(Year)	9. B	irthplace (Si Country)	tate or Foreign
P	,		Usual Residence of Decedent									NOV. U	, 1 7 1	4 Fell	nsylva	anıa
Ivlan	how	_	10a. State 10b. Cou	nty		10c. C	ity, Town or L	ocation		_					10d. Insid	de City Limits
Ma	89-f	cto		imore			Cat	onsvi	.11e						10	Yes 2X No
di F	01.2 N. D.	Dire	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What C	Country?	
ath v	s 23	by Funeral Director	709 Maiden C						1228					.S.A.		
er de	E E	une	11. Marital Status		. Was Decedent Armed Forces?		J.S. 13.	Was Deced If Yes, spec	lent of Hi ofly Cuba	span <i>i</i> c Origi n, Mexican,	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		 14. Race - Am Black, Wh 		ın,
irs af	0	by	1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divore		1 ☐ Yes 2 🔯 If Yes, Give Year or Dates:	NO		1 ☐ Yes	2 <mark>⊠</mark> No	Specify:				Specify: TJ	hite	
within 72 hours after death with the Maryland	eture	ted	15. Dece	ent's Educa	tion		16a. Dece	dent's Usua	I Occupa	tion			16b Kir	nd of Busines		
A IA I 3-0030	e E	ple	(Specify only hig		Completed) College (1-4or t	541	(Give	kind of wor DO NOT us	rk done d e retired,	uring most o	of worki	ng			a maastry	
N P	gen th	Completed	Elementary/Secondary (0-1:		College (1 401)			Sa1	es				C	ement (Co.	
nd 2 should be file	at Hygie d other event, II	Be (17. Father's Name (First, Midd		_					18. Mother	s Name	(First, Middle,	Maiden	Sumame)		
y outdit	and Mental B marked of umatic eve	ဥ	Sampson New	on He	wlett					Sar	ah N	laude Do	her	ty		
2 sh		6	19a. Informant's Name/Relation		•							l Route Numbe				
and I	Health		John N. Hewle	: C C	(Son)	20h [int R		Bar Har				
Dermit. Pages 1 a	or or	'	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Crematic		noval from State	(Place of Dispo cemetery, crei	natory or of	her place	· 1				cation - City o		
	rtmer rtent njury		`4 □Donation 5 □ Other			Bal	to./Wa	sh. C	rema	tory 8	3–15	-2004	Laur	cel, Ma	rylan	d
permit.	Depa Impo any ii		21. Signature of Funeral Servi	E LICENSEE	22 ~	1008	See W	itzke	Fun	eral 1	Home	of Cat Catonsv	onsv	ville,	Inc.	
E:	nysician and Medical xaminer itausit transit	Examiner	23a. Rart. Ehter the disease shoek or heart failure. I Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complication only one	Due to (or as	a conseq	quence of):	er the mode	of dying	, such as ca	ardiac o	r respiratory arr	est,		Approxi Interval Onset a	mate Between and Death
The law requires that the death certificate be executed	igned by the attending physicia be detached for use as the buri	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant cond		. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown buting to death bu	2 ☐ Feta time of d	il death 3 [Ectopic pre Other (spe	cify)	n in Part I.		23e. Did tob		3d. Date of de Month e contribute to	Day	Year of death?
aduire	been sig	edt										1 □ Ye	s 2	No 3□Pi	robably 4	Unknown
	certificate has be ector, page 2 sho	e Completed	25. Was case referred to medi	and a							_		ned?	24b. Were au prior to death? 1 ☐ Yes	utopsy findin completion of	igs available of cause of
Physician:	nis cert direct	0 B	examiner?		pital:	ot 2 🗆	ER/Outpatien	t 3 DO	Other			(Check only on				
ending	eath. or: After th he funeral	Certification: T	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	ling tigation	28a. Date of Injur (Month, Day	y	28b. Time of Injury		c. Injury	at	2	ne 5 🗌 Reside 8d. Describe ho			cify)	
pitel or At	i Die	Certifi	4 Homicide dete	mined	28e. Place of Injubulding, etc	(Specify	y) 					8f. Location (Str City or Town	, State)			lumber,
the Hospitel	within 24 hours a To the Funerel I completely filled	Medical	one)	a examiner	ian: To the best of On the basis of and manner sta	examina	wledge, death tion and/or inv	estigation,	n my opi	nion, death	olace, a occurre	d at the time, da	ite and p	lace, and due	to the caus	
To	0 →	_	29b. Signature and title of certi	ıσι					License					signed (Monti		,
		-	mat					D	30	989		F	PUP	ust 1	3 20	Hox
)			30. Name and address of person	n wno 'comp	neted cause of de	ath (Item	1 23a) (Type, I	rint)		0					16.6	
	Sta Registr	1.0	31. Date lied (Month, Day, Yea		72. Registra	r's Signa	turd	port	JO 4	an C	nd)	ceur	1 (notoc	SVIII	Z
	riegisti	Z11	AUG 1 7 2	400	1	/		r								

			1 - For State Registrar	State of Ma	aryland		artment of F <i>tificate of</i> .		Mental Hygi	ene g. N62 0 0 4	25710
	Division		Decedent's Name (First, Middle, Last)	/- 1					2. Date of Death		3. Time of Death
	Physici /Medio		Leona H	7rsch					AMONTH ST	-13, 2004	9:50AM
	Examir	ier	4e. Fecility Name (If not institution, give s				4b. City, Town, o	_	ath	4c. County of Death	
	Europol		Franklin Woods Nur 5. Social Security Number 6. Sex		ter e (In yrs. las	st birthdav)	Roseda If Under 1 Year	le If Under 24 Hr	s. 8. Date of Birth	Baltimo	
r	Funeral Director			M 2/2/F	90	Yrs.	Months Days	Hours Mir		Year) Coll 13 Marv	place (State or Foreign intry) 1 and
	pu ,		Usuel Residence of Decedent 10a. State 10b. County			Town or Lo			000.1713		
	Aaryla shor	5	Maryland Baltimore	2	Essex		cation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	rect	10e. Street and Number		100002		10f. Zip Code		10	g. Citizen of What Cou	
	th with	Funeral Director	809 Myrth Avenue				21221			U.S.A.	, .
	r dea	Iner		12. Was Decedent I Armed Forces?	Ever in U.S.	13. \		lispanic Origin? (an. Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Married 3√3 Widowed 4 ☐ Divorced	1 ☐ Yes 2020 If Yes, Give Year or Dates:	10		Yes 2 XX	Specify:	,	Specify:	
21215-0036	2 hou	ted t	15. Decedent's Educ	cation		16a. Deced	lent's Usual Occup	ation	11	6b. Kind of Business/Ir	ite
215	thin 7 en n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)	life. L	kind of work done of NOT use retired	during most of wi d)	orking		,
7	led wi lygien har th		8			Sales	Clerk			epartment :	Store
Maryland	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or Itema 23a or 28a-f show umatic event, the Medical Examiner Fusal be notified at	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle, Ma	aiden Surname)	
Z Z	should nd Me mark imati	2	Franz Trunk 19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Mailin	a Address (Street		Beilein Bural Route Number	City or Town, State, Zij	2 Code)
Ž	alth a alth a 27 is		Bruce Hirsch (Son)							yalnd 2122	
Baltimore,	of He		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ R.	amoual from State	20b. Plac	ce of Disponetery, cren	sition (Name of natory or other place	(9)	Date 20	Oc. Location - City or To	own, State
Ĕ	Pag tment tant: I		*4 ☐ Donation 5 ☐ Other (Specify)		Gard		f Faith	Aug.	17,2004 B	altimore, N	Maryland
Bai	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f show amportant: If Itam 27 is marked other than "natural", or Itema 23a or 28a-f show ampt inury or other traumatic event, the Marical Examiner mast be notified at once.		21. Scool ner Luneral Surve License	0	_	22	Name and Addres	ss ol Facility UZdzinsk	i Funeral	Home, P.A.	•
0			23a. Part1. bater the disease, or complic	cations that caused	the death.		407 OLG	Lastern	Avenue. Es	ssex. Marv	Approximate
	Physician		shock, or heart failure. List only on Immedinte Cause (Final disea, or condition resul n is death)	e cause on each lin	10. + 0 0 0			. 4	0	1	Interval Between Onset and Death
8	/Medical		results, it death)	Due to (or as	a con uer		gestive	near	Lan	ire	
	Examiner	Ļ.	Sequentially list conditions, b	6		200 W					
	nsit	Examiner	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or set	s consequa-	nea ofj:					
o	execu an and rial-tra	Exai	that initiated events cresulting in death) Last	Due to (or as a	a consequer	nce of):					
68760,	ficate be executed physician and s the burial-transit	edical	d								
9 ×	entific ding pl	/Med	IF FEMALE:	20.16	4						
Вох	eath certil attending for use a	Physician/M	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of deliver	ery Day Year
P.O.	t the d by the ached	hysl	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unknown		0	omor (speeny)				
S,	The law requires that the death certil te has been signed by the attending bage 2 should be detached for use a	by P	Part II. Other significant conditions con	tributing to death bu	it not resultii	ng in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
Vital Records,	w require been si should b	ted	Morexia, 179	Mal Top	rilla	tion,	Strok	e_	1 Tes	2 □ 110 3 □ Prob	abiy 4 Unknown
Sec	e law has b	Completed							24a. Was an autopsy	prior to co	psy findings available mpletion of cause of
			05.11							d? death?	2 No
5	ysician: The is certificate hi director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatier	nt 2□FB	VOutpatient	3□ DOA Othe		ath (Check only one)	ce 6 □Other (Specif	
0	ding Phys h. After this funeral di	T:uc	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28	Bb. Time of Injury	28c. Injury Work	at	28d. Describe how		/)
SIO	tandii leath. lor: Al	catle	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(,/	/	,=.,		Yes 2 □ No			
Division of	or At after Direc	Certification;	4 Homicide determined	28e. Place of Inju building, etc	ry - At home . (Specify)	e, larm, stre	et, factory, office		28l. Location (Stree City or Town,	et and Number or Rura State)	I Route Number,
	spita hours meral y filled		29a. Certifier 1 Certifying Phys	ician: To the best o	f my knowle	dge, death	occurred at the tim	e, date and place	e, and due to the caus	se(s) and manner as si	ated
	To the Hospital or Attanding Physician: To the Hospital State and the Total To the Funeral Director: After this certified completely filled in by the funeral director.	edical	(Check only 2 Medical Examin	er: On the basis of and manner sta	examination	and/or inv	estigation, in my op	pinion, death occ	urred at the time, date	and place, and due to	the cause(s)
	To To Com	Σ	29b. Signature and title of certifier	P			29c. License	~ 1 1		. Date signed (Month,	**
,			10m Elmond	non M	DC	110	1 124	5766	/1	rigust 1	3,2004
8	4	ŀ	30. Name and address of person who con	DS Frank	lin S	sa) (Type, F	Print)	0312 B	1tim-	ngust 1	>7
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	0	VIIVE, OT	-10,01	VI JIVIUIC,	~ ND 017	-) /
100	Registra	ar	AUG 1 7 2004 &	Equip Com	ful	4000	KI				

	_	For State Registrar		State o	of Ma	ryland		artmen ertificat				lental Hy	giene Reg. No	200	L	25720
Discolution		1. Decedent's Name (First,	Middle,	Last)								2. Date of De.	ath Da	v Y	eer	3. Time of Death
Physicia /Medica				Jame	es T	imot	hy Ha	usch				August				1:29 A ^M
Examine		4a. Facility Name (If not ins	titution,	give street and nu	imber)			4b. City,	Town, or	Location	of Death		4c.	County of	Death	
	*.	Montgomery		-				Olne	-	If I I and a s	04111-			lontgo		
Funeral		5. Social Security Number		6. Sex 1⊠M 2□F			a <i>st birthd</i> ay Yrs.	/) If Under Months		If Under Hours	Min.	8. Date of Bird (Month, Da	y, Year)	50 5		place (State or Foreign ntry)
Director	ŀ	213-56-4255 Usual Residence of Decede				54						Apr 17	, 19	50 V	vasn	ington,DC
land	1		County			10c. City	, Town or I	_ocation							1	0d. Inside City Limits
Man,	ō	MD Ho	war	đ		Hia	hland									1 ☐ Yes 2 🙀 No
r 28g	Director	10e. Street and Number						10f. Zip	Code				10g. Cit	izen of Wh	at Cour	ntry?
h with	a D	13303 Clark	svi	lle Pike				207	777				U.	S.A.		
dear	Funeral	11. Marital Status		12. Was Dec	edent Ev	ver in U.S	3. 13	. Was Dece	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	-	14. Race -	Americ White,	
or th	Y Fu	1 Never Married 2			2 X No)		1 🗆 Yes		Specify:		,		Specify:		
filed within 72 hours after death with the Maryland Hygiene. ther than "neturel" or Items 23e or 28e-f show ent, the Madical Examinar must be notified at	d by	3 Widowed 4 Div		Year or D	Dates:		10. 5									
net adice	Completed			s Education t grade completed)			(Giv	edent's Usua e kind of wo DO NOT u	rk done a	turing mos	t of work	ing	16b. K	ind of Busi	ness/ind	dustry
withir ene. then	щ	Elementary/Secondary (0	0-12)	College (1-4or 5+	•)		que De					Fur	nitur	:e	
filed Hygi sther	ပိ	17. Father's Name (First, M.	Aiddle, L	ast)				-		18. Mothe	er's Name	(First, Middle,	Maiden	Surname)		-
ld be ental ked c	To Be	A. Paul Hau	ısch							Mari	an F	isher				
shou and M mar	-	19a. Informant's Name/Re	ationsh	ip (Type, Print)			19b. Ma	ling Address	(Street a	and Numbe	er or Aura	al Route Numbe	er, City o	r Town, St	ate, Zip	Code)
alth alth a	Н	Annette R.	Haus	sch /sr	ouse						Pik	e, High	land	l, Mar	yla	nd 20777
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinator must be notified at once.		20a. Method of Disposition 1 Darial 2 XCrem		3 Demoval from	State	20b. PI	ace of Disp emetery, cr	oosition (Nar ematory or o	ne of ther place	e)	(Date	20c. Lo	ocation - Ci	ty or To	own, State
Pag ment ent: t		`4 □ Donation 5 □ Ot	ther (Sp	ecity)	State	W.	Arund	del Cr	emat	ory .	Aug	16, 04	Ode	nton,	Ма	ryland
eparti eparti port y inj		21. Signature of Funeral S	ervice L	icensee				22. Name ar Donald	d Addres	s of Facili	ral :	Home, P	. A.			
20529		1 HUGH	- Suc	Ilh		0077								land	207	07-4389
		23a. Part1. Enter my disar shock, or he of fail re	se or a e. List a	complications that only one cause on	caused t each line	the death e.	. Do not e	nter the mod	le of dying	g, such as	cardiac	or respiratory ai	rrest,			Approximate Interval Between Onset and Death
Physician		Immediate Cause (Fixal disease or condition		_a_ Mult	iple	e Or	jan F	ailure)							days
/Medical Examiner		resulting in death)	1				ence of):									
Carried State	_	Sequentially list conditions					Obst	ructio	on						-	days
nsit .	nine	cause. Enter Underlying Cause (Disease or injury	* 4				Cance	r								weeks
sicien and burial-transit	Examiner	that initiated events resulting in death) Last		٠,		consequ		<u>+</u>							-	weeks
bur ficie	cai			d												
fic p p	ed															
h certific ending p	2 V	IF FEMALE: 23b. Was decedent pregna		23c. If yes, ou		f pregnar		□Ectopic p	egnancy					23d. Date of		-
ed for u	Sicia	in the past 12 months 1 Yes 2 No	i ?		nant at ti	ime of de		Other (sp						Month	1	Day Year
at the ded by the detached	Physician/M	9 Unknown	a madiai au				late en ten ale e			- :- D I		220 Did to	aba saa i	on contribu	ito to th	ne cause of death?
ries that	ρ	Part II. Other significant co	ondition	is contributing to c	aeam out	i not resu	iitiing ai tiio	underlying d	ause give	ının ranı	•	1 🗆 1		_	Prob	4.1
w require	eted											9.00	-			
e law has b	Completed								·			24a. Was autop		24b. We	or to cor	psy findings available apletion of cause of
r: The licete har r, page												1 □ Yes	2 No			2No
sicie	o Be	25. Was case referred to n examiner? 1 Tes 2 No	песіса	Hospital:	· ·		TR/Outpati	ant 2 7 D	Othe			Check only o		c Cohar	10	
Phys or this oral di	-	27. Manner of Death		28a. Date	Inpatien of Injury	,	ER/Outpati 28b. Time		8c. Injury	at		me 5 🗌 Resid 28d. Describe f				//
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)		30. Name and address of p	PERSON	who completed cau	A OL GE	atti trem	23a) (Typ	non	万书	Milla	ile	M	7	20	3	36
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Registra	ar	AUG 1 7 20	004	pener		1	14									

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

crn	1		1 - State Registrar	State of Marylan	d/Depa per in <i>Cei</i>	artment of h	pallbyand Death	lental Hygie	ene	25721
	Physici /Medio		Decedent's Name (First, Middle, Last) David Wayne H					2. Date of Death Month August	Day Year 14 2004	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s 2912 Bauernwood A 5. Social Security Number 6. Sex	venue, 1st Fl		4b. City, Town, or Baltin	Location of Death OCE If Under 24 Hrs.	8. Date of Birth	4c. County of Death	
	Funeral Director		212-11-5097 Usual Residence of Decedent	(M 2□F 34	Yrs.	Months Days	Hours Min.	Sept. 15	1970 M	
	the Marylan 28a-f show	Director	MD Baltimor 10e. Street and Number		y, Town or Lo	ville		100		10d. Inside City Limits 1 Yes 2 No
21215-0036	within 72 hours after death with the Maryland ane. Then "neturel", or Items 23e or 28a-f show Ita Moulcel Extrailmer is ust be notilled at	by Funeral	10313 Greentop Ro	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	16a. Dece	Nas Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ Xo dent's Usual Occup: kind of work done c	Specify:	pecify Yes or No- Rican, etc.)	USA 14. Race - Ameri Black, White Specify: W	can Indian, etc. 'hite
ณ	be filed within 72 ho tal Hygiene. Id other then "netui event, II e M. C.C.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) n/a		tore Cler	k		Food Ser	vice
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the M.	To Be	Norman Lee Hall,				Teresa	e (First, Middle, Ma	er	
σ	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other treumatic once.		19a. Informant's Name/Relationship (Ty, Arnold Albrecht/s 20a. Method of Disposition 1☆ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functal Service ☐ Crees	tep-father 20b. P c emoval from State Du	10313 Place of Dispo emetery, crer laney	Greento sition (Name of natory or other place Valley Me	p Rd., (8/18/ emorial G	Cockeysvi 04 ardens T	City or Town, State, Zi IIIe, MD 21 c. Location - City or T Imonium, IIaney Vall m, MD 210	1030 own, State
	Ale be executed his circums and his circums and his circums and his circums are circums are circums and his circum	icai Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Seizure dis	sorder uence of): uence of):	er the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetel 4 □ Pregnant at time of de	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of deliving Month	ery Day Year
ecords, P.	quires that the signed by all the detact	by	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.		cco use contribute to t	
		Be Completed	25. Was case referred to medical				26. Place of Deat	24a. Was an autopsy performed 122 Yes 2	d? prior to co	ppsy findings available impletion of cause of 2 No
Jivision of	or Attending Physiter death. Irector: After this In by the funeral di	Certification; To	examiner? 1 Xes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Cetemined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At house the building, etc. (Specify found at house)		128c. Injury Work 1□\	at ?? /es X INo	28d. Describe how unknown 28f. Location (Stree City or Town, S		lernwood Av
	To the Hospitel of within 24 hours at To the Funerel D completely filled i	edical C	29a. Certifier 1 Certifying Physical Control Check only one) 2 Medicel Exemination	sicien: To the best of my knowner: On the basis of examinational and manner stated.	wledge, death	occurred at the time restigation, in my op	e, date and place,	and due to the caus	se(s) and manner as s	tated.
•	To the within To the comple	Me	29b. Signature and title of certifier JOYLLE J 30. Name and address of person who co	1 4 4		Print)	C.M.E.	Au	Date signed (Month,	2004
	Sta Registr		31 Date filed (Month Day Vear)	nberg M.(). 32. Fügigrar's Signa 2004	turo		eet, Balt	люге, Ма	aryland 213	201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		- State Regist AMEND ITEM #5 PER INF G836 10 PER		Reg.	0001	25722
Physician /Medical		1. Decedent's Name (First, Middle, Last) Thomas Harrison		Date of Death Month IGUST	Day Year 10, 2004	3. Time of Death 16:50 M
Examiner		4a. Facility Name (If not institution, give street and number) 134 North Curley Street	4b. City, Town, or Location of Death Baltimore		4c. County of Death	/ A
Funeral Director		5. Social Security Number 212-58-5968 053		Date of Birth Month, Day, Ye pt 25,		ce (State or Foreign y) MD
ith the Maryland or 286-f show in natified at	TOI	10a. State			100	d. Inside City Limits 1 XYes 2 □ No
ath with the 23a or 28 ust be not	rai Dire	10e Street and Number 134 North Curley Street	10f. Zip Code 2 1 2 2 4	10g.	Citizen of What Country Inited Sta	y? ates
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23a or 28e-f show ming or other treumatic event, the Midical Examinar must be notified at once. To Be Completed by Funeral Director	a by runer	1 Never Married 2 N Married 1 Tyes 24 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Americar Black, White, etc Black	
Maryland 21215-0036 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 Is marked other than "neturel; or treumatic event, the Midfall Exami To Be Completed by F	hipiere		dent's Usual Occupation a kind of work done during most of working DO NOT use retired) Housekeeping	16b	Kind of Business/Indu	_
yland 2 uld be filed Mental Hyg arked other atic event,	ם ו	17. Father's Name (First, Middle, Last) Santee Harrison	18. Mother's Name (Fin Rose An			
y, Mary and 2 sho salth and 1 n 27 is me ner treume		Betty Harrison/wife 134	ing Address (Street and Number or Rural Ro North Curley Stre	ute Number, Cit eet Bal	ty or Town, State, Zip C Ltimore, Mi	D. 21224
Baltimore, sermit. Pages 1 ar Department of Heal mportent: If item any injury or other pince.		4 Donation 5 Dotner (Specify)	n Cemetery 2004	17 Ba	Location - City or Town	
Ball permit Depart Impor eny in		21. Signature of Funeral Service Ucensee	2. Name and Address of Eacility alvin L. Williams .O. Box 11651 Bal	Funer	al Service, MD. 212	229 P.A.
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic (Due to (or as a consequence of):	ter the mode of dying, such as cardiac or res		lr.	pproximate hterval Between onset and Death
executed exact an and rial-transit	í	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):				
ecords, P.O. Box 6876 law requires that the death certificate be as been signed by the attending physici. 2 should be detached for use as the bupleted by Physician/Medical	ysicializmedic		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Da	ay Year
S, igne igne be c	2	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		o use contribute to the o	
He he he	and line			24a. Was an autopsy performed?		
vision of Vital F Attending Physicien: Th r death. ector: After this certificate by the funeral director, pag fification: To Be Co	2	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury			- ' ' '	SCENE
Direction risatte rel Direction led in I		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	ocation (Street : City or Town, Sta	and Number or Rural Re ate)	oute Number,
thin 24 hours in the Hospitel thin 24 hours in the Funerel I mapletely filled made and made and made and made and Celebrate and Celebrate and made and celebrate and celeb		29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deat 2 ☑ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and d vestigation, in my opinion, death occurred at	ue to the cause the time, date a	(s) and manner as state and place, and due to the	ed. e cause(s)
To the within To the comp		29b. Signature and title of certifier	29c. License number O.C.M.E.		Date signed (Month, Day	
3		30. Name and address of person who completed cause of death (Item 23a) (Type, ANA RUS (O, MD 1111)	Penn Street, Baltimon			
State Registrar		31. Date filed (Month, Day, Year) AUG 1 7 2004 32. Registrar's Signature	Sparks			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:35 A.™ Dorothy M. Himmel August 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) **Examiner** 449 Glendale Avenue Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) May 9, 191 Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number **Funeral** Months 1 □ M 2 🗙 F 85 1919 219 30 2617 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10b. County tems 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 217 No Maryland Anne Arundel Glen Burnie Direct 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 449 Glendale Avenue 21061 U.S. death v Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: ģ Year or Dates: White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fred Eklund Minnie Eckles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Janet Estep / Daughter 2811 Oak Grove Avenue Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 8/13/2004 Baltimore, Maryland 21. Signal re of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LEN LENDION **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? ō 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 No 1 Yes certificate or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Yes 2 No 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by t 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2 DZJIII 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hammo nisaite 31. Date filed (Month, Day, Year) 32. Registrar's Signature State souks Registrar 2004

			1 - For State Registrar	State of Ma		epartmer Certificat			Mental H	ygiene	04	25726
	Physic		Decedent's Name (First, Middle, Last Total CONT M. The	,					2. Date of D	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of Deat	Hugi		ty of Death	16.00
	Funeral	-	1 Peninsula Legion 5. Social Security Number 6. Se		(In yrs. last birth			If Under 24 Hrs	8. Date of B	irth Vacar)	9. Birthp	Olace (State or Foreign
	Director		222-12-5965 Usual Residence of Decedent	M 2□F	76 Y	Months	Days	Hours Min.	8. Date of B	3 - 28"	Snow	place (State or Foreign http://html
	ryland show	_	10a. State 10b. County		10c. City, Town						1	0d. Inside City Limits
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	3a or	10 10	Lot 14, Holiday E	states		10f. Zip	.000 19966			10g. Citizen o	f What Cour	itry?
	r death ems 2	inera	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.			ispanic Origin? (S n, Mexican, Puer	Specify Yes or N	o- 14. R	ace - Americ	
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<u>(</u>	ABLY IBING 2 should be f 3 and Mental B 18 marked of raumatic eve	2	Walter Jenkins 19a. Informant's Name/Relationship (T)	ma Rriet)	105.8	Apilina Autonom	(Ct-===1		a Bratto			
			Yvonne Harmon / Da		96	05 Tell	Lico	Place, (clinton,	, Maryla	n, State, Zip 1 n d 2	0 7 35
:	Sairimore, bermit. Pages 1 ar Department of Hea mportant: if tem: nny Injury or othe		20a. Method of Disposition 1 X8urial 2 Cremation 3 F	Removal from State		crematory or o	ther plac		Date	20c. Location	-	
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265	ofou, ate be executed bhysician and the burial-transit	Exa	that initiated events resulting in death) Last	v	consequence of)				1010			
√ 0	do / ou, ificate be e. g physician as the buria	dlca	•	d								
8	BOX OR eath certific attending p for use as 1	an/Me	230. Has decedent pregnant	3c. If yes, outcome o		3 ☐Ectopic pr	edbancy		-	23d. D	ate of delive	ry
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X C	res that the de signed by the a	P P	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	ne underlying c	ause give	n in Part I.	23e. Did	tobacco use cor	tribute to th	e cause of death?
5	w require	eted										ably 4 Donknown
Jenkins z	The tav	Completed								psy ormed?	prior to condeath?	osy findings available inpletion of cause of
en	- 10	Be C	25. Was case referred to medical examiner?					26. Place of Dea	1 ☐ Yes	2 N o	1 🗆 Yes	2□ No
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000	Jing Jing Afte fune	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju	iry M	8c. Injury Work 1 Y	ai ? ′es 2 □ No	28a. Describe	how injury occu	rrea	
Wilson	or Atte or Atte after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home, farm (Specify)	, street, factory	, office		28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,
2	To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funeral Director: Atter this certific completely filled in by the funeral director.	Medical Co	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Exemi	sicien: To the best of ner: On the basis of and manner stat	examination and/o	leath occurred a or investigation,	at the time in my op	e, date and place inion, death occur	, and due to the	cause(s) and m	anner as sta and due to	Ited. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	4 - "		29c	. License	number		29d. Date sign	ed (Month, E	Jay, Year)
	/		P /2 Dan.	M.D.		Į.	5	7952		8/16	1200	4
	()		30. Name and address of person who co Babilal Des,	166 /	ath (Item 23a) (Ty	ST #	304	B . Sa	lisbu	4 MD	218	04
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	and i						

			For State Registrar	State of M	larylan	•	artment rtificate			and M	-	giene Reg. No. 0	0 4	2572	: 5
п	Physicia	an	1. Decedent's Name (First, Middle, La Ann Jones	st)							2. Date of De Month	Day.	Year 2004	3. Time of D	_
	/Medic	al	4a. Facility Name (If not institution, give	e street and number	.)		4b. City. 1	Fown or	Location		August	· · · / -	2004 Inty of Death	1650	<u></u>
	Examin	er		HEALT		RE	BA	LT	Mol	_		40. 000	inty of Boutin		
	Funeral		Social Security Number 6. 8	Sex 7. A		last birthday)	If Under Months	1 Year_ Days	If Under Hours		8. Date of Bir (Month, Da	th	9. Birthr	place (State or F	Foreign
Ш	Director		188-09-4340	I □ M 2 🖾 F	87	Yrs.	Wortus	Days	Tiodis	1411112	Dec. 2	3,1916		sylvani	ia
	land	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							0d. Inside City	Limits
	Mary Ind	tor	Maryland Baltim	ore	Cat	tonsvi	11e							1	∑∑ No
	th the	lrec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Coul	ntry?	
	23a ust b	ral	6008 Central Av	enue				2120				U.S.A	•		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural, or items 23a or 28a-f show any injury or other traumatic event, If a Madical Examination and once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 1 If Yes, Give Year or Dates	? No		Was Decedent Yes, spec		ispanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White, acify: W		
Ö	2 hou	Completed by	15. Decedent's E			16a. Dece	dent's Usua	l Occupa	ation	e af warde		16b. Kind o	f Business/In	-	
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2	led willygien her th		11			S	eamsti	cess	40.14-4-	d- N	/P**		Lothin	g	
and	d be findal Head of	Be	17. Father's Name (First, Middle, Last Unknown	,					18. Mothe		(First, Middle nown	, маідеп Бил	name)		
Z	should nd Me mark imatic	우	19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Address	(Street a	and Numbe		l Route Numb	er, City or To	wn, State, Zip	Code)	_
Ž	alth a alth a 27 is		Rosina Campagna	(Friend)		6008	Centr	al .	Avenu	e Ca	tonsvi	lle, Ma	arylan	1 21207	
ore,	es 1 a of He fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Domoural from State	20b. P	lace of Dispo emetery, cre					ate		on - City or To		
Ĕ	Pages ment of I ent: If its lury or o		`4 □Donation 5 □ Other (Speci		? I .	klawn				3-17-	2004	Baltin	nore,	Marylan	ıd
Baltimore, Maryland 21215-0036	pemit Depart Import any in		21. Signalure of Juneral Service Live	Telson	le	- W	Name and itzke 530 Ec	Fund Fund Imon	s of Facilit era1 dson	y Home Ave	of Cat Catons	tonsvi] ville,	le, In Maryla	nc. and 2122	28
п			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each	d the death line.	h. Do not en	ter the mode	of dying	g, such as	cardiac c	r respiratory a	rrest,		Approximate Interval Betwe Onset and De-	
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Myoc	ARDI	AL	INF	ARC	CTIC	N			(NEHOL	
н	Examiner		1	Due to (or a	s a conseq	uence of):									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Et at Underlying Cause (Disease or injury	b. Due to (or a	s a conseq	uence of):						-			
	cuted nd ransit	Examiner	that initiated events	c											
, 0,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):									
8760,	icate be executed physician and s the burial-transit	dlca		d											
P.O. Box 6	death certif e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	Ideath 3[□Ectopic pre						Date of delive	ary Day Yea	ar
	requires that the neen signed by th hould be detache		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying ca	use give	en in Part I		23e. Did t	obacco use c	ontribute to th	ne cause of dea	ath?
rds	n requires been sign should be	Completed by	Severe MITRI	AL REGU	RG17	ATIO	N, UI	RIN	ARY		1 🗆	Yes 2□No	3 ☐ Prob	ably 4 Wink	known
900	aw Is b	plet	BLADDER CA	NCER. F	1Y DR	ONE	PHRO	SIS	2		24a. Was		b. Were auto	psy findings ava	railable
Ä	Th ate pag	Com		ock.							perfo	rmed? 2 No	death?	2 No	30 01
/ita	siclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				0#		of Death	(Check only o	опе)			
of	Phys this aldii	. To	1 Yes 22No 27. Manner of Death	28a. Date of In		ER/Outpatier		A Othe Bc. Injury	4 🗀 NU	-	me 5 Resi			y)	
on	ding h. After fune	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	M	Work	ດີ Yes 2 ∐i		LOG. Describe	now injury occ	Zarred		
Division of Vital Records,	l or Attendater deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Ir	njury - At ho	ome, farm, st	reet, factory,	office			28f. Location (Street and Nu	mber or Rura	l Route Numbe	∋ <i>r</i> ,
ā	tel or A	Cert	4 Tromode	ballaling, e	atc. (Specin)	r) 				Į.	City of 101	wn, State)			
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Place (Check only one) 2 Medical Exa	nysician: To the bes miner: On the basis and manner s	of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	ne, date an oinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and date and plac	manner as s e, and due to	ated. the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier						number			29d. Date sig			
•	,		- Chama			-		18	362	2-3		AUGU.	ST, 13	200	4
į	β		30. Name and address of person who CHA UHAN, CHA	NDANA	YD, SI	TMIF	Print) AGN	ES	HEA	LTH	CARE	, BA	LTIM	ORE, M	1229 7D.
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 7 2004	32. Hegis	trar's Signa	15	pork	2							

JONES, ANN

		1	For State	ND TTEM #	State of Ma 2&3 PER PI	-		artment of H <i>rtificate</i> of L			Reg. No.	004	25726
	Physicia		Decedent's Name	(First, Middle, Las	t)			LIJOT OIL		Month	Day	.10-04 / Year 1 , 200	3. Time of Death 23:45pm
	/Medio	al -	4a. Facility Name (If	FRED	W JOH	ANSEI	N	4b. City, Town, or	Location of De	Augu:		County of Deat	
	Examin	eı			rial Hos	pita	1	Frede	rick		I	Freder	ick
	Funeral Director		5. Social Security Ni 505-09-92		X 7. Age	93	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of 8 Min. (Month, 1 March	Birth Day Year) 29	9. Birti 1911	hplace <i>(State or Foreign</i> untry) Nebraska
	and w	-	Usual Residence of 10a, State	Decedent 10b, County		10c. City, 7	Town or Lo	ocation					10d. Inside City Limits
	Maryla 1 sho	- 1	MD	Frederic	ck		ferso						1 □ Yes 🔏 🖟 No
	r 28a-	rec	10e. Street and Nun	nber				10f. Zip Code			10g. Citi	izen of What Co	ountry?
	th with	al D	5103 Ella	Court				21755	5		U.	S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Exertil er hust be netitied at	Completed by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed	ed XXMarried 4 Divorced	12. Was Decedent Armed Forces? 12. Wes 2 1 If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	ispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or luerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: W	
9-0	72 hou	ted	(Spec	15. Decedent's Ed ify only highest grad				dent's Usual Occup		working	16b. Ki	ind of Business/	Industry
Maryland 21215-0036	within 7 ene. than "r	nple	Elementary/Seco		College (1-4or 5	i+)	life.	DO NOT use retired	1)		11 C	Corrora	nmant (NCA)
121	e filed within al Hygiene. I other than ' vent, tre Ma	Ö	17. Father's Name	(First Middle Last)	2 Years		Ana	lyst	18. Mother's	Name (First, Midd			nment (NSA)
and	d be f antal l ced ol	To Be	Frederick		Johansen				Annie	William	s		
Z Z	2 should be and Mental is marked (aumatic ev	ř		ame/Relationship (7			19b. Mailir	ng Address (Street	and Number of	r Rural Route Nur	nber, City o	or Town, State, 2	Zip Code)
	s 1 and 2 should Health and Mer Item 27 is marke other traumatic		Madge Joh	nansen /	spouse		5103	Ella Cou	ırt Je	fferson,	Mary	land 2	1755
ore,			20a. Method of Disp		Removal from State	20b. Plac	ce of Disponence of the contract of the contra	osition (Name of matory or other place	ce)	Date	20¢. Lo	ocation - City or	Town, State
Ē	Pages ment of t ant: If its lury or o			5 Other (Specify		MD V		ns Cemete		16/2004	_	ltenham	, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fu	neral Service Licen		100770		රිසිට්ඩ්ප්ර්ර්ලි 13 Talbot				aryland	20707
			23a. Part1. Enter the shock, or hea Immediate Cause		olications that caused one cause on each li			100			arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	in	aDue to (or as	a conseque		il her	NMOS	chase			days
		Jer	Sequentially list co	nmediate III	b. Due to (or as	a conseque	nce JI):						
	xecuted and Il-transii	Examiner	cause. Enter Unde Cause (Disease or that initiated events resulting in death)	S 🔳	cDue to (or as	a conseque	nce of):						
68760,	icate be executed physician and s the burial-transit	edical E			d								
O. Box 68	ne death certif the attending thed for use a	Physician/Mec	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknown	months? ⊒No	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal d	leath 3[□Ectopic pregnancy	у		-	23d. Date of del Month	livery Day Year
Δ.	res that the igned by be detact		Part II. Other signi	ficant conditions c	ontributing to death b	out not result	ing in the u	ınderlying cause gıv	en in Part I.	23e. D	id tobacco i	use contribute to	the cause of death?
rds	quires n sign ald be	d by	Corono	ur art	ery dis	eas	2			1	☐ Yes 2	XNo 3□Pr	robably 4 Dünknown
Records,	The law require sate has been si page 2 should l	Completed		*	•					24a. W au pe 1 🗆 Ye	itopsy erformed?	prior to death?	utopsy findings available completion of cause of
Vital	ysician: The is certificate director, pag	Be	25. Was case reference examiner?	rred to medical				- 0.1		Death (Check on	ly one)		
of \	Physic this c	2	1 ☐ Yes 2		Hospital: 1 Inpati		R/Outpatie	nt 3 DOA		ng Home 5 R			ecify)
uc	ding h h. After funer	lon	27. Manner of Deal	tn 5 ☐ Pending investigation	28a. Date of Inju (Month, Da		Injury	Wor	rk?]Yes 2 □ No		so non inju	ily occurred	
Division	or Attending Physician: ther death. Director: After this certifics in by the funeral director.	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not b	e 28e. Place of In	jury - At hom tc. (Specify)	ne, farm, st	treet, factory, office	_	28f. Locatio	n (Street ar Town, State		ural Route Number,
_	To the Hospital or Attem within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	nysician: To the best niner: On the basis of and manner si	of examination	ledge, deal	th occurred at the tinvestigation, in my o	me, date and popinion, death	place, and due to to occurred at the time	he cause(s ne, date an	s) and manner as d place, and due	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and	title of certifier	Lassin	+		29c. Licens	se number	890	29d. Da	ate signed (Mont	th, Day, Year)
١	G		30. Name and add		completed cause of	death (Item 2			-	Swanne	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1712171	Co
	St	ate	31. Date filed (Mor			rar's Signatu	IL6	, ,,,,,,				<u> </u>	
	Regist		ΔΠΟ	1 7 2004	here	a h	4	Sparker					

			for State Registrar	State of M	arylan		artment of I		ınd M		giene Reg. No?	n la	257	27
	• •		1. Decedent's Name (First, Middle, La	ist)	_		<u>-</u>			2. Date of Dea Month		Vaar	3. Time o	
п	Physicia /Medic		Marsh		Lee		Jo	nes		8 -		Year	6:10	Ам
}	Examin		4a. Facility Name (If not institution, given	re street and number)			4b. City, Town,	or Location o	f Death		4c. Count	y of Deat	h	
			Manor Care Nur				Baltimo		2416- 1					
e	Funeral Director		219-20-3025	Sex 7. Ag	9e (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day 10 2	r. Year)	9. Birti	nplace (State untry) MD	o <i>r Foreign</i>
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside C	City Limits
	Manyt f ehc	ŏ	MD NA		Bal	timor	e						1 X Yes	2 🗌 No
	the 1	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Co	untry?	
	h with	<u>=</u>	3612 Segouia A	WA.			21	1215			U.S	. A .		
	deat	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of If Yes, specify Cut		gin? (Spe	cify Yes or No-	14. Ra	ce - Ame	rican Indian,	
9	or It		1 Never Married 2 Married	1 XYes 2 ☐ If Yes, Give Year or Dates:	No		1 ☐ Yes 2X No			,	Speci	fy:		
ğ	hours turel,	Q D	3 XWidowed 4 □ Divorced			162 Door	dont's Heuri Occur	ention			16b. Kind of B		Black	
7	be filed within 72 hours after death with the Maryland id Hygiene. A clother than "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event. The Martinal Exeminar must be notified at	Completed by	15. Decedent's E (Specify only highest gr	ade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	pation during most ed)	of workii	ng	160. Kind of t	ousiness	industry	
77	iene.	Eo	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	Servi	ce Tech	nnicia	an		AT &	T C	ompany	Y
ğ	Hyg other	BeC	17. Father's Name (First, Middle, Las					18. Mothe	r's Name	(First, Middle,	Maiden Suma	me)		
<u> a</u>		To E	Howard Jones					Eliza	abet	h Adar	ms			
Maryland 21215-0036	and and series		19a. Informant's Name/Relationship	(Type, Print)		19b. Maifi	ng Address (Stree	t and Numbe	r or Rura	l Route Numbe	r, City or Town	, State, Z	ip Code) 2	1133
	를 C 를		Michelle Abram	s-Daught	er	8741	Meador	/ Hei			Randa			Md
Ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [☐Removal from State	C	emetery, crei	osition (Name of matory or other pla	1		ate	20c. Location			
altimore,	t. Pa rtmen rtant:		*4 □Donation 5 □ Other (Special		Gar	risor	Fores	t Vet	. 8/	13/04	Owing	s M	ills,	Md
Ba	permit. Page Department Important: if any injury o		21. Small re of Funeral Service Lice	A. Sho	mper		Name and Addr March F 1300 Wal	TH We	st Ave,	Balt	imore	Md	2121	5
	я		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cause one cause on each l	d the death	n. Do not en	ter the mode of dy	ing, such as	cardiac o	r respiratory are	rest,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition	a Myr	200	14P	esia						Onset and	Death
	/Medical Examiner	-	resulting in death)	Due to for as	a consequ	uence of):								
		- S	Sequentially list conditions, if any, leading to immediate	b. Due to for as	a cunseur	uon ca offi.								
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury											
o î	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):								
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		d										
89	ng ph	Med	IF FEMALE:											
Вох	eath certific attending p	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Feta	death 3	Ectopic pregnanc	су				ate of deli		Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of di	eath 5L	Other (specify) _							
۵.	uires that the de signed by the a Id be detached f		Part If. Other significant conditions	contributing to death	out not resi	ulting in the u	inderlying cause g	ven in Part I.		23e. Did to	bacco use cor	ntribute to	the cause of	death?
Records,	puires n sign ald be	d by								1 🗗 🗡	es 2 No	3 🗌 Pro	obably 4 🗆	Unknown
00	w require been si should b	Completed								24a. Wasa	an 24b.		topsy findings	
	The law te has age 2 :	mo								autop perfor	med?	prior to death?	ompletion of a	cause of
ita	Physician: The this certificate had director, page	BeC	25. Was case referred to medical					26. Place	of Death	(Check only or		103	2	
>	Physician: r this certifica ral director, r	To	examiner?	Hospital: 1 fnpati	ent 2	ER/Outpatie	nt 3 DOA	her: 4 Nu	rsing Hor	ne 5 Resid	ence 6 🗆 Ot	her (Spec	city)	
Division of Vital	ding After fune	Certification;	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury	W	ıryat ork?]Yes 2 □ l		28d. Describe h	ow injury occu	rred		
/isi	l or Attending after death. Director: After in by the fune	flca	3 Suicide 6 Could not	be 28e. Place of In	jury - At ho	ome, farm, st	reet, factory, office				treet and Num	ber or Ru	ral Route Nur	nber.
á	ا الله الله	Serti	4 Homicide	building, e	tc. (Specif	y)				City or Tow	m, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying P (Check only ane)	hysician: To the best miner: On the basis and manner s	of examina	wledge, deat tion and/or in	th occurred at the to estigation, in my	ime, date and opinion, deat	d place, a th occurr	and due to the o	cause(s) and m date and place	anner as , and due	stated, to the cause((s)
	o the	Me	29b. Signature and title of certifier				29c. Licer	se number			29d. Date sign	ed (Month	n, Day, Year)	
•	- s - ō		122 A	00	12.4	200	1+0	0050	142	24	8-1	0-0	24	
	$/\chi$		30. Name and address of per п who	completed cause of	death (Item	n 23a) (Type.	Print)			+ 10	- 0	-		
	le '		The second secon	rdi, 20	E. "	Time	Print)	Vd.	, Su	le# 1s	1/1/	non	um)	ND
3	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 7 2004	/32. Regist		ature	ports						_,_	. 3

1.1	VAISTIV	C.F.	1- State of Maryla		artment of H			iene	25720
			Decedent's Name (First, Middle, Last)				2. Date of Deat	th	3. Time of Death
	Physici /Medio		Scott Andrew Katsikas				August	Day Year 2004	1 19:39 M
}	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Deat	h	4c. County of Death	1
			Carroll Hospital Center			unster		Carroll	L
	Funeral Director		+FM 2□E	rs. last birthday) 24 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) Cou	nplace (State or Foreign untry) Vland
	yland ow			City, Town or Lo	cation			1	10d. Inside City Limits
	Many -1 sh	ţ	Maryland Howard	Ellico	tt City				1 □Yes 2√2 No
	or 286	Director	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What Cos	untry?
	23e (23e)	<u>a</u>	3441 Apt. A Plumtree Drive		21042	2	1	United Stat	ces
	lems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White	
36	hours after death with the Maryland tural', or liems 23e or 28e-1 show al Exarta ret must be modified at	by Fi	1 Never Married 2 Married 1 Yes, Sive 1 Yes, Give Year or Dates:		1 ☐ Yes 2 € No		,,		vhite
٥ ٻ	hour sul E		3 Widowed 4 Divorced Year or Dates:	16a Doco	dent's Usual Occup	ation			
215	nin 72 n "nat	Completed	(Specify only highest grade completed)	(Give	kind of work done of DO NOT use retired	during most of war	rking	16b. Kind of Business/li	ndustry
212	e filed within at Hygiene. I other then "	mo;	Elementary/Secondary (0-12) College (1-4or 5+) 12 1	Mob	ile DJ			Self Empl	oved
pu	be filed within 72 hours after death with the Marylan nat Hygiene. ed other then "natural", or liems 23e or 28e-f show of other then "natural" or nust be notified at event, the Madical Examerements.	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle, N		.oyea
<u>la</u>	ould be Mental arked o	To	George Katsikas, Jr.			Linda C	rompton		
Maryland 21215-0036	Sh man		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zi	
			Linda Snead - Mother	4711	Winksley	Court E		City, Maryl	and 21043
0	ges 1 if of F if ite or ot		20a. Method of Disposition 20b 1 → Burial 2 □ Cremation 3 □ Removal from State	. Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date 2	20c. Location - City or T	own, State
Baltimore,	it. Pa rtmer rtent: njury				ge Mem. I		.9/04 I	Elkridge, M	laryland
Ba	permit. Pages 1 and Department of Healt importent: if Item 2 any injury or other 2 once.		21. Signature of Funeral Service Licensee	Ga:	Name and Addres		eral Home	e At MMP	Inc.
			23a. Part 1. Enter the disease, or complications that caused the de	eath. Do not ent	<u>50 Washir</u> er the mode of dvin	igton Blv g. such as cardiac	d. elkr	e At MMP. idge, Maryl	and 21075 Approximate
}	Physician /Medical		Immediate Cause (Final		MOVNO		HEAD		Interval Between Onset and Death
	Examiner		Due to (or as a cons	equence of);					
	•	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events c.	equence of):					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events						
Ö,	e exe ian a urial-l	EX	resulting in death) Last Due to (or as a cons	equence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical	d						
9 ×	eath certifi attending for use as		IF FEMALE: 23c. If yes, outcome of prec	202004					
Вох	atten for u	cian	in the past 12 months?	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
o.	that the de led by the a detached	Physician/Me	1 Yes 2 No 4 Pregnant at time o	- death 5	Cuter (specify)				
٣.	The law requires that the tte has been signed by thoage 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not r	esulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
Vital Records,	v require been sig should b	ed					1 ☐ Yes	s 2⊠No 3⊟Prot	bably 4 Unknown
ဝ၁ခ	as be	Completed					24a. Was an	24b. Were auto	opsy findings available
ď		E O					autopsy perform 1 Yes 2	prior to co death?	ompletion of cause of 2□ No
/ita	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one		2010
		္ရ	Yes 2 No Hospital: 1 ☐ Inpatient 2	K ER/Outpatient	t 3□ DOA Othe	er: 4 Nursing H	ome 5 Resider	nce 6 Other (Specif	5y)
n c	ding Ph h. After th funeral	lon:	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)		Work		28d. Describe how		
isic		icat	2 Accident investigation 3/13/04	12:06 1		Yes 2 No			
Division of	l or A after Direct	ertification:	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	nome, tarm, stre	et, factory, office		City or Town,		
	e Hospitel 24 hours a e Funerei I letely filled	aic	29a. Certifier 1 ☐ Certifying Physicien: To the best of my k	nowledge, death	occurred at the tim	e date and place	and due to the car	CTIN DR; WESTI	tota d
	To the Hospitel or Atten within 24 hours after deal To the Funerel Director: completely filled in by the	Medicai	one) 2 Madical Examiner: On the basis of examination and manner stated.	nation and/or inv	estigation, in my op	pinion, death occur	rred at the time, dat	te and place, and due to	o the cause(s)
	Z Wil		29b. Signature and title of certifier		29c. License			d. Date signed (Month,	
n			30. Name and address of person who completed cause of death (It	22-) = :	1	O.C.M.E.		August 14,	2004
10			AMA RUBIO, 40	111		eet, Bal	timore, M	Maryland 21	201
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Sig	Dure do	all				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 8, ['] 2004 Geraldine T. Kochanek August 4:30 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6920 Donachie Road #704 Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 29, 19 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Yrs. 360-20-4785 Director 76 Illinois Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "natural", or Iteme 23e or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Cilizen of Whal Country? 6920 Donachie Road #704 21239 permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23e eny injury or other traumatic event, tra Medical Examinar modes. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Potempa Celia Rokicki ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roman Kochanek/spouse 6920 Donachie Road #704 Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service L ROTIALO S censee Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 man 23a. Part1. Inter the disease, or commerciation. Mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Caus Final disease or condition Multifor me Physician alio blastoma 5months /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Jo in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ed bluods Completed 1 🗌 Yes 2 No 3 Probably 4 □Unknown peen 24a Wasan 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate has page 2 autopsy 1 Yes **≱**□ No Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home PResidence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 🕱 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural
2 Accident death within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number Paul B Froly M. D. Physician 044314 August 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore Paul B. Fowler, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State books Registrar 2004

		1 - For State Registrar	State of Maryland / D	Pepartment of He Certificate of D		Reg	ene . Ng? () () (,	25730
Physici /Medic Examin	cal	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s	Kizer Casim	ir Kunak 4b. City, Town, or t	ocation of Death	2. Date of Death Month August	Day Year 13, 2004 4c. County of Dea	3. Time of Death 2:00P
Funeral Director		2603 Page Drive 5. Social Security Number 212-20-0420 Usual Residence of Decedent	70		dalk If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		more thplace (State or Foreigountry) ryland
Sa-f show	Director	10a. State 10b. County	10c. City, Town	or Location	Е	undalk		10d. Inside City Limit
23a or 2 ust be no		10e. Street and Number 2603 Page Drive	2	10f. Zip Code	21222		. Citizen of What Co United St	•
"natural", or items 23a or 28a-f show sales. Examiner must be notified at	by Funeral	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22XNo If Yes, Give Year or Dates: 	13. Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 ☒No		acify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
e. ian "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 Years	cation 16a. Completed) College (1-4or 5+)	Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	ion rring most of worki	ng 16	b. Kind of Business	/Industry
ental Hygiene. ked other than "natu ic event, the Medical	To Be Con	12 Years 17. Father's Name (First, Middle, Last) Daniel Kunak		Machinist		(First, Middle, Ma. Nellie Iw	iden Sumame)	orporation
item 27 is marked other traumatic ev	Ţ	19a. Informant's Name/Relationship (Ty) Wilma E. Clary /	Companion 2	Mailing Address (Street and 603 Page Dri	od Number or Rura	I Route Number, C	ity or Town, State,	Zip Code) 222
ant: If		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R ☐ ☐ Donation 5 ☐ Other (Specify)	Sacred	Disposition (Name of crematory or other place) Ht of Jesus	Cem. 8/		c. Location - City or Dundalk	Town, State
Importa any Inj	i fa	21. Symure of Funeral Service Ligense	Canlo	22. Name and Address Duda-Ruck 7922 Wise	Funeral	Home of Malk. Ma	Dundalk,	Inc. 21222
ysician ledical aminer		23a. #3rt1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not be cause on each line. Bashic Due to (or as a consequence of	Carcino	such as cardiac c	r respiratory arrest	9	Approximate Interval Between Onset and Death ID MON (4)
rsician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of					
ned by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of del Month	livery Day Year
G G	by	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given	in Part I.			the cause of death?
: certificate has been si irector, page 2 should t	Completed					24a. Was an autopsy performed	prior to	utopsy findings availa completion of cause (
0 D	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	Othor		(Check only one)	e 6 Other (Spe	cify)
를 들	Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. T	jury Work?	it 2	28d. Describe how		,
fter		3 Suicide 6 Could not be	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	2	City or Town, S	et and Number or Ru State)	ural Route Number,
offer		4 HOTHICIDE						
4 hours after death. Funeral Director: After ely filled in by the funer		29a. Certifier Certifying Phys	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occurred at the time Vor investigation, in my opin	, date and place, a nion, death occurre	and due to the caus and at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
offer	Medical Certif	29a. Certifier Certifying Phys	IOF: On the basis of examination and	Vor investigation, in my opin 29c. License n	number 46 98	ed at the time, date	se(s) and manner as and place, and due Date signed (Monti	h, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2004 August seener /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arundel edical Annapoli 5
If Under 1 Year If Under 24 Hrs. Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Year Hours 1□M 2XF 190-12-2481 August 16,1922 Pennsy Yrs. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ent; If item 27 is marked other than "netural", or items 23a or 28e-f show ury or other treumatic event, the Medical Exameter must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director Anne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15A d -ove 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes. Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Unite Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jamuel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other treu 20b. Place of Disposition (Name of penatery, crematory or other place)
Heffiner Funeral hapel Ra vaughter MD 21146 Tound Cove Baltimore, Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ¹ 4 ☐ Donation 22. Name and Address of Facility permit. al ervice Lensee 21. Signatur Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on cast line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, Due to for as a consequence of Be Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and I-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): burialattending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Nnpatient 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 17 2004

30. Name and address of person who comp

29a. Certifier

(Check only one)

29b. Signature and title of certifier

10 9009 Registrar's Signature

se of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date pigned (Month, Day, Year)

DHMH 17 Rev 1/2001

within 24 hours a To the Funerel D

cpm 04-05118 ROBERT KEITT UNK 04-269

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Keitt 05:16 AM August 07, 2004 Michael Ace /Medical 4b City Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4800 block of Herring Run Drive Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. Director ΜĎ 19 218-08-5458 Usuat Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show r Items 23a or 28a-f shov uner oust be netitied at XXYes 2 No Director MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 4007 Primrose 21215 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: the Medical Exact Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Flementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed llth grade Pages 1 and 2 should be filed viment of Health and Mental Hygie tant: If item 27 is marked other jury or other traumatic event, It other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Michael Anthony Keitt Bobbie Ann Waiters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4007 Primrose Ave, Baltimore, ce of Disposition (Name of 20c. Location Lucille Keitt-Grandmother Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or once. King Memorial Park 8/16/04 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tomediate Cause (Final isease or condition resulting in death) Priysician Shotaun multiple wounds /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE use 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown signed b Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2XXXIo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 □ No XXYes 2 No Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 X Yes 2 □ No ို Division of 28a. Date of Injury (Month, Day Year) After the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 4:59 AM 5 Pending 1 Natural death. 8-7-04 1 ☐ Yes 2 💢 No investigation SUBJECT SHOT 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4800 block of Herring Run Dr. Baltimore, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide street To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 10, 2004 ND a 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patricia Aronica-Pollak M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 7 2004

Registrar

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Theodore King M.D.

31. Date filed (Month, Day, Year) AUG 1 7 2004

n		-	1 - State of Maryla State of Maryla	nd / Department of Health and M Certificate of Death		25734 25734
	Physicia		1. Decedent's Name (First, Middle, Last) CET OLD W. Levell		2. Date of Death Month	Day Year 3. Time of Death
ı	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) Shock TRAUMA LANGE OF MO.	4b. City, Town, or Location of Death 3. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth	4c. County of Death N/A
	Funeral Director		5. Social Security Number 216-84-3218 6. Sex 17. Age (In yrs 216-84-3218 Usual Residence of Decedent	Yrs. Months Days Hours Min.	8. Date of Birth	9. Birthplace (State or Foreign Country) Maryland
	Maryland a-f show	tor		City, Town or Location		10d. Inside City Limits 1 X Yes 2 ☐ No
	with the 3a or 28	i Direc	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Country? USA
136	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene did other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be inclified at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0036	filed withIn 72 hor Hygiene. other than "natura ent, the Wedical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Never Worked	ing 16	Sb. Kind of Business/Industry ${ m N/A}$
Maryland 2	should be filed with nd Mental Hygiene markad other tha matic event, the h	Be Co	12 17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	
aryla	should nd Men marka umatic	J.	Thomas Lewis 19a. Informant's Name/Relationship (Type, Print)	Joa 19b. Mailing Address (Street and Number or Rura	n Canby al Route Number, (City or Town, State, Zip Code)
	1 and 2 Health a em 27 is ther tra		Joan Cochin/Mother 20a. Method of Disposition 20b.			Maryland 21223 DC. Location - City or Town, State
altimore,	pernit. Pages 1 and Deportment of Health Important: If Item 27 any njury or other to		1 ☐ Burial 2 Cremation 3 ☐ Removal from State	etro Crematory Inc. 8/16	/04	Baltimore, Maryland
Balt	permit. Pag Depertment Important: any njury o		21. Signature of Funeral Service Iconsee Thomas Gregor	22. Name and Address of Facility Cremation Society 299 Frederick Road	Baltimo	re. Maryland 21228
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	I damage due to a	or respiratory arres	Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions b. 5 KU	fracture due to a	J. H	e may m
8760,	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consider the cause of the cause	equence of):	Wash BA Wee	
O. Box 68	death certifi e attending ad for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	etal death 3 Ectopic pregnancy	_	23d. Date of delivery Month Day Year
s, P.	The law requires that the de ate has been signed by the a bage 2 should be detached f	ρ	Part II. Dther significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did toba	accoluse contribute to the cause of death?
Reco		Completed			24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vita	Physiclan: The la rthis certificate has iral director, page 2	To Be (25. Was case referred to medical examiner? 1 Yes 2 □ No Hospital: 1 ☑ Inpatient 2	Other	h (Check only one)) ice 6 ⊟Other (Specify)
Division of Vital Record	or Attending fter death. Director: Afte in by the fune	Certification: T	27. Manner of Death 1 Natural 2 Accident investigation 28a. Date of Injury (Month, Day Year) 2 Accident 1 S Pending 28a. Date of Injury (Month, Day Year) 2 Accident 1 S Pending 28b. Time of Injury 28c. Injury at Work? 1:38 P M 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	28d. Describe how driver of which col 28f. Location (Stre City or Town, at Greenw	vinjury occurred Subject was a	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C		knowledge, death occurred at the time, date and place, ination and/or investigation, in my opinion, death occur	and due to the cau	use(s) and manner as stated.
	To the To the Comp	M	29b. Signature and title of certifier April A. Kukuon -	29c. License number / 6/114	294	d. Date signed (Month, Day, Year) 8/15/04
9			30. Name and address of person who completed cause of death (II	II D.O. 11 S. Gr	eene Stre	eet, Baltimore, Maryland
	Sta Registi		AUG 1 7 2004 32. Registrar's Sig	B Sports		

			For State Registrar	State of M	Maryland /	•	nent of H		d Mental Hy	giene Reg. No. 2	2004	25735
e	Q		1. Decedent's Name (First, Middle	e, Last)					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		Blanche	M.	Leathe	rwood			August		2004	9:30 A ^M
	Examin		4a. Facility Name (If not institution	n, give street and numbe	9r)	4b.	City, Town, or	Location of D			ounty of Death	
			Manor Care Nurs	sing Home -	Rossvil	le	Roseda.	le		Ba	ltimore	
	Funeral Director		5. Social Security Number 217-26-1658		Age (In yrs. last t	oirthday) If	Under 1 Year Inths Days	If Under 24 I Hours &	Hrs. 8. Date of Bin Min. (Month, Da August	h y, Year) 31, 19	9. Birthp Coun MD.	ace (State or Foreign try)
	pu >		Usual Residence of Decedent 10a. State 10b. County		100 City To	wn or Locatio			<u> </u>		140	Od. Inside City Limits
	shov	-	_ ^								"	1 Yes 2 XNo
	Ba-f	Funeral Director		imore	MIC	ldle Ri				10 000		
	or 2	Dir	10e. Street and Number			10	Of. Zip Code				n of What Coun	try?
	ath v	ra	6823 Columbia 1				2122			USA		
	er de	nue	11. Marital Status	12. Was Decede Armed Force	s?	13. Was	Decedent of Hi s, specify Cuba	spanic Origin' n, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	- 14	. Race - Americ Black, White,	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Give		101	res 2⊠No	Specify:		S	pecify: Whit	e
ô	72 hours after death with the Maryland naturel', or items 23e or 28e-f show disel Examinet must be rodified at	edt	21	nt's Education		ia Decedent's	Usual Occupa	ation		16h Kind	of Business/Inc	lustry
15	in 72 in 72 in 16	olet	(Specify only highe	st grade completed)		(Give kind	of work done of IOT use retired	luring most of	working	700. 11110		
21215-0036	within iene.	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Waitre	255			Res	staurant	
	Hyg Hyg other		17. Father's Name (First, Middle,	Last)		_war care		18. Mother's	Name (First, Middle,	-		
an	ld be ental ked d	To Be	Ulysses Meekin	S				Bertha	a Todd			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23e or 28e-f show any injury or other traumatic event, the Medical Exact intermet Le rediffied at Once.	-			19	9b. Mailing Ad	Idress (Street a	and Number o	r Rural Route Numb	er, City or T	Town, State, Zip	Code)
	and 2 salth a n 27 is		Thomas Campbel	1 Sc	n 6	5823 Cc	olumbia	Road,	Middle Ri	ver,	MD. 212	20
ē,	t Head the other	1	20a. Method of Disposition		20b. Place	of Disposition	Name of	a) 7\1	Date 18	20c. Loca	ition - City or To	wn, State
) E	Pages nent of int: If its ury or o							" Al		Notti	ngham.M	ID.
Baltimore,	artm ortar injur							s of Facility				
B	permit. Departr Imports any inju		Khithom	Part. Enter the disease or reapplications that caused the death. To determine the disease or respiratory arrest, Separtha Todd								
	1		23a. Part1. Enter the disea	r complications that cause	sed the death.							Approximate Interval Between
	Physician		Immediate Cause (Final									Onset and Death
	/Medical		disease or condition resulting in death)	a.METAST Due to (or	as a consequence		US CEI	da Crar	CLAOMA			3 MOS.
	Examiner			CEREBE	ROVASCU	LAR A	CCIDEN	T WIT	H LEFT I	EMIE	LEGIA	5 DAYS
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequenc							
	outed Id ransit	Examiner	that initiated events	G								
o,	an ar	EX	resulting in death) Last	Due to (or	as a consequenc	e of):						
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Ical		d								
9	tifica ng ph as th	ed	IE SELVALE							100		
Вох	eath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1☐Live birth	me of pregnancy	ıth 3⊡Ecto	ppic pregnancy			23	d. Date of delive	•
	deal	3 <u>C</u>	in the past 12 months? 1 □ Yes 2 录No		t at time of death		er (specify)				Month	Day Year
P.0	by the	Physician/M	9 Unknown									
	res that the de signed by the a l be detached f	by F	Part II. Other significant conditi	V. 17 . 17 . 1			, ,	en in Part I.		_		e cause of death?
Records,	w require been signshould b	ted	SMALL CEL	L CARCINO	MA RIG	HT LU	NG		150	Yes 2	No 3 Prob	abiy 4 □Unknown
oc o	aw is b	Completed							24a. Was		24b. Were autop	osy findings available inpletion of cause of
H	The tate has page	omo								rmed? 2⊠ No	death?	2 € No
Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medica examiner?	31				26. Place of	Death (Check only o	опе)		
of V	S S	0	1 Yes 2 No	Hospital: 1 Inp	atient 2 ER/	Outpatient 3	DOA Othe	4 14 14 11 211	ng Home 5 ☐ Resi	dence 6 [☐Other (Specify)
0			27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Date of I (Month,	njury 28b Day Year)	. Time of Injury	28c. Injun Work	at c?	28d. Describe	now injury	occurred	
<u>Ö</u>	Attending r death. sctor: After y the fune	atle	2 ☐ Accident invest	igation		1	M 1□	Yes 2 □ No				
Division	r Atto	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Place of	Injury - At home, etc. (Specify)	farm, street,	factory, office		28f. Location (. City or To		Number or Rura	Route Number,
	rs after or rs after or relation											
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical		ng Physician: To the be I Examiner: On the basi and manner	s of examination.							
	To the within 2 To the comple	₩ M	29b. Signature and title of certific		1		29c. License	e number		29d. Date :	signed (Month, I	Day, Year)
	F 3 F ŏ		1 man	2	M	.D.	D17	728		Augu	st 16,	2004
			30. Name and address of person	who completed cause			L					-
-	\mathcal{U}		Ba Yin Oung				ir Rd.	Ð	alto., N	ID 2	1236	
	St	ate	31. Date filed (Month, Day, Year		istrar's Signature				arco., I	ے بی	1200	
	Regist		AUG 1 7 20	304 Se	va &	1 A	racks/					

			1 - For State Registra MEND ITEM	State of Maryland /	Depa 8/1	rtment of	f Health and of Death	Mental Hy	/giene	004	25736
П	Physic	ian	1. Decedent's Name (First, Middle, Las	()				2. Date of D Month	eath Day	Year	3. Time of Death
	/Medi	cal	Dorcas Antoinette 4a. Facility Name (If not institution, give			4h Chu Tour	n, or Location of Dea	Aug.		004	6:15 p ^M
	Exami	ner	1500 Pickett Rd.	Street with manipery			erville	un		County of Death	
	Funeral		5. Social Security Number 6. Se		7.	If Under 1 Ye Months Da	ar If Under 24 Hr				place (State or Foreign ntry)
	Director		210-93-5818 Usual Residence of Decedent	^{3 M 2} X F 86	Yrs.	Monais Bu	ys riodis iviii	June			
	/land		10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
	a-f sh	tor	MD Baltimor	e Luth	nervi	lle					1 ☐ Yes 2 ☐ No
	or 28	Olre	10e. Street and Number			10f. Zip Cod	е		10g. Citiz	zen of What Cou	ntry?
	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show lical Exercities: aust be rudified at	Funeral Director	1500 Pickett Rd.	10 Wee Dearter Free in 110	140.11		21093		US		
' O	fter de r Itam Ilrer	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No			of Hispanic Origin? (Suban, Mexican, Pue	rto Rican, etc.)	0-	 Race - Ameri Black, White, 	
93	ral', o	þ	3 ☐Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	1	Yes 2	No Specify:			Specify: W	hite
5-0	"natu	Completed	15. Decedent's Edi (Specify only highest grad	ucation 16 de completed)	(Give I	lent's Usual Ockind of work do	ne durina most of wo	orking	16b. Kir	nd of Business/In	dustry
21215-0036	filed within Hygiene. Ithar than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use rei	tired)				
9	2 should be filed withir and Mental Hygiene. Is marked othar than aumatic evant, I're Ms	Be Co	17. Father's Name (First, Middle, Last)		пот	emaker	18. Mother's Na	me (First, Middle		n home Sumame)	
/lan	uld be Mental rrked c	To B	Charvel Thomas P	ierce			Elizabe	eth Caul	field		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. I that The marked other than "netural", or items 23a or 28a-1 show item 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, I've Medical Extracting to a second or the modified at		19a. Informant's Name/Relationship (T	ype, Print)	9b. Mailin	g Address (Stre	eet and Number or F			Town, State, Zip	Code)
	of Health itam 27		Henry F. Pierce/b	rother 1	500	Pickett	Rd., Lut	herville			
Baltimore,	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locat								
	그 든 뿐 글		4 □ Donation 5 □ Other (Specify,21. Signature of Functions	Duite			ematory 8	15/04	La	urel, MI)
B	Depar Impo any ir			lagle			Funeral H Idonia Rd	ome_of I	Dular	ney_Valle	ey, Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. De	o not ente	or the mode of o	IGONIA RO tying, such as cardia	c or respiratory a	nrest,	MD 21	093 Approximate Interval Between
	e be executed /Medical Examiner e prival-transit e prival-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. End Stade Due to (or as a consequence) Due to (or as a consequence) c.	e of): e of):	he mes	bemonts	a			
O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	Due to (or as a consequence d	th 3□	Ectopic pregnal Other <i>(specify)</i>			2:	3d. Date of delive Month	ery Day Year
rds, P.	w requires that been signed I should be det	þ	Part II. Other significant conditions co	ntributing to death but not resulting	in the un	derlying cause	given in Part I.			se contribute to th No 3 ☐ Prob	ne cause of death?
		Completed					· · · · · · · · · · · · · · · · · · ·	24a. Was auto perfo 1 ☐ Yes		prior to con death?	psy findings available impletion of cause of
<u> </u>	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient - PAER/0			Date	ath Check only o			
lon of	ing After une	H	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Outpatient Time of Injury	28c. In	4 Nursing i		5 XX sidence 6 □Other (Specify) Describe how injury occurred			
Division	tal or Attand rs after death al Diractor: , ed in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, offic	ce	28f. Location (City or To	Street and wn, State)	Number or Rura	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Directory of the Completely filled in b	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.						te to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)		
	To To Com							signed (Month,	*		
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blvd., Balto.						3-04	118 2		
?											
State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature						ute 500,	Goo	od Samar	ritan Hosp		
	Registr	_	AUG 1 7 2004	Deneva ,	9	Loan	17				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Yea **Physician** 5:45 AM Jeanne. Regina August 14, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Stella Maris Hospice Timonium If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
May 31, 19 Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2X F 76 Yrs Director 217-24-0811 Baltimore Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director PA York York 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with or Items 23a USA 170 Lester Ave. 17404 Completed by Funeral deeth permit. Pages 1 and 2 should be filed within 72 hours after dee. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" ..." any injury or other treumatic even. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 X No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Pharmacy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank M. Ford R. Helen Rapp ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Rainflower Path, Unit 102 Sparks, MD 21152 John P. Luers/Son 20b. Place of Disposition (Name of comptery crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition August 18, 2004 1 Burial 2 □ Cremation 3 □ Removal from State ^ 4 □ Donation 5 □ Other (Specify) Pikesville, MD 21. Signature of Euneral Service Licensee Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael J. Flagle 23a. Part . Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician BREAST CANCER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy į in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2□ No 1 ☐ Yes 1 Yes of Vital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 1 ☐ Yes 2 📆 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Injury 1 Natural 2 Accident 5 | Pending М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 22. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 7 2004 State Registrar

DHMH 17 Rev 1/2001

2004

AUGUST 14,

JEANNE LUERS

				partment of Health and Mertificate of Death	Mental Hygie	2001.	25738		
	Physici /Medic		Decedent's Name (First, Middle, Last) SYLVIA	LEVIN	2. Date of Death	Day 2004 ear	3. Time of Death 1:44 PM		
	Examin		4a. Facility Name (If not institution, give street and number) 6210 PARK HEIGHTS AVENUE #605	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	N/A		
	Funeral Director		5. Social Security Number 219-58-6963	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth NOV . 20 , 19	9. Birth Cou	place (State or Foreign intry) MD		
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	Location			10d. Inside City Limits		
	be Mar	Director	MD N/A	BALTIMORE			1 Yes 2 □ No		
	h with 3a or	al Dir	10e. Street and Number 6210 PARK HEIGHTS AVENUE #605	10f. Zip Code 21215	10g.	Citizen of What Cou	USA		
980	d within 72 hours after death with the Maryland liena. r than "natural", or Itams 23a or 28a-1 show Its M-circal Examinar must be multied at	by Funeral	3 X Widowed 4 □ Divorced Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🂢 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:			
Maryland 21215-0036	0 0 5	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWNE	edent's Usual Occupation re kind of work done during most of worki DO NOT use retired) ER	ing 16b	. Kind of Business/Ir	TRAVEL		
land	d ta b se	o Be (17. Father's Name (First, Middle, Last)	INGSTON 18. Mother's Name	e (First, Middle, Maid	,	PALMAN		
	s 1 and 2 should if Health and Men Item 27 is marka other traumatic			lling Address <i>(Street and Number or Rura</i> CLIFFDWELLER COURT			*		
Baltimore,	m Q 1-		I (A bunar 2 Cremation 3 Hemoval from State	position (Name of ematory or other place) AI CEMETERY 8/13/		Location - City or T			
Balti	permit. Page Department Important: It any Injury o		21. Signature of Faneral Service Licensee	22. Name and Address of Facility SOL	LEVINSON	l & BROS.,	INC.		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac of six heart prillers heart dikka u			Approximate Interval Between Onset and Death		
8760,	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C	rheart dikan	<u> </u>				
.O. Box 68	The law requires that the death certificate has been signed by the attending places as should be detached for use as to as a second to the second be detached for use as the second seco	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year		
<u>α</u>	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to t	he cause of death?		
al Records,	- C	Completed	Hypertension		24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available impletion of cause of		
f Vital	yaic is ce direc	To Be		26. Place of Death ent 3 □ DOA Other: 4 □ Nursing Hor	me 5 Residence	6 □Other (Specia	(v)		
ion of	ling After Tune	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 1 Natural (Month, Day Year)	of 28c. Injury at	28d. Describe how in		,,		
Division		Certific	3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 5 ☐ Could not be determined 6 ☐ Could not be determined 6 ☐ Could not be determined 7 ☐ Could not be determined 8 ☐ Could	treet, tactory, office	28f. Location (Street City or Town, St		al Route Number,		
	To the Hospital or within 24 hours after To the Funaral Dirticompletely filled in the completely filled in the formal or the filled in the formal or the filled in the fil	edical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, dea 2 ■ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a newstigation, in my opinion, death occurred.	and due to the cause ed at the time, date a	e(s) and manner as s and place, and due to	tated. o the cause(s)		
•	To the I within 2 To the I complet	Σ	Mila Wir., NO	29c. License number \[\Delta \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Date signed (Month, $f/I/Of$	Day, Year)		
)(Y		30. Name and address of person who completed cause of death (Item 23a) (Type	1800 Old Obust	Rd, Ba	Stinore,	DOUNG		
	Sta Registi	State 31. Date filed (Month, Day, Year) 32 Registrar's Signature							

			ame (First, Middle, La:	State of Ma #23a, 27, 28				2. Date of Dea		3. Time of Death
Physic	ian		IANO MON	,				Month AUG.	11, 2004 Year	0647 A M
/Med Exami		4a, Facility Name	o (If not institution, given SITY HOSPI'	e street and number)			or Location of Death		4c. County of Deat	th
Funeral Director		5. Social Security	1	ex 7. Age	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		hplace (State or Foreign buntry)
ס		Usual Residence	9 – 9 1 7 1 of Decedent		10c. City, Town or	4 14		03/2	8/2004 M	ARYLAND 10d. Inside City Limits
72 hours after death with the Maryland naturel', or Items 23a or 28a-f show digal Examiner must be notified at	ector	MD	N/	A			MORE CI			1 XYes 2 ☐ No
with the	Ö	10e. Street and I	Number			10f, Zip Code			10g. Citizen of What Co	ountry?
PS 23	erai	1558 11. Marital Statu	CLIFTON	AVENUE 12. Was Decedent E	ver in U.S. 1	3 Was Decedent of H	21217	acity Yas or No-	USA 14. Race - Ame	erican Indian
permit. Pages 1 and 2 should be liled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturel", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never M	arried 2 Married d 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:	0	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	e, etc.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician lugust 04:15pm Joseph McGrier 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LHIMORE Ba Hospital Good Samazitan 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 25, 1 **Funeral** 1**X**) M 2□ F 154-58-0022 44 Director 1959 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exercities In ust be rediffed at once. MD Directo Baltimore 1√2 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1714 Bradford Street 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No U.S. If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married unk Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 💢 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Good Samaritan Hospital 5601 Loch Raven Blvd Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ₺ Other (Specify) in state 21 Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ica 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Oause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnent at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2. No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and Atle of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODO Cesarin

Registrar DHMH 17 Rev 1/2001

State

oaks

560/ Lock Raven Boulevard, BaltmorEMD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. 160R Hotaturov

2004

31. Date filed (Month, Day, Year)

AUG 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	*	si	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Elizabeth D. Michael			Aug.	11 20	004 9:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of I	Death
			Broadmead		Cockeysville		Balti	more
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ear)	Birthplace (State or Foreign Country)
	Director		219-18-1586 1 M 2 X 81 Y	S.		July 18	1923	MD
	and and	-	10a. State 10b. County 10c. City, Town	or Lo	cation			10d. Inside City Limits
	Maryl f sho	ō	MD Baltimore Cocke	vs	ville			1 □ Yes 2√2 No
	1 the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of Wha	at Country?
	within 72 hours after death with the Maryland ene. than "natural", or Itama 28a or 28a-f show fra Medical Exeminar maral be modified at	Q E	13801 York Rd., #E4		21030		USA	
	deati	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-		American Indian, White, etc.
9	or Its		1 Never Married 2 Married 1 Yes 2 Mo		1 ☐ Yes 2 ☐ No Specify:			white
	ural',	Completed by	3 Wildowed 4 Divorced Year or Dates:			10	b. Kind of Busin	
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2	withir ene. then	d m	Elementary/Secondary (0-12) College (1-4or 5+)		nemaker		Own H	ome
Itimore, Maryland 21215-003	Hygic Hygic other ent, II		17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma.	iden Sumame)	
an	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. is marked other than "natural", or Itama 23a or 28a-f show aumatic event, if a Medical Examinar mant be rediffed at	To Be	Candler B. Dial		Mary	Elizabeth	n Holde	n
ary	ges 1 and 2 should t of Health and Men if item 27 is marke or other traumatic.			Mailir	ng Address (Street and Number or Ru	ral Route Number, C	ity or Town, Sta	ite, Zip Code)
Š	and 2 lealth a m 27 is		Margaret Michael Thompson/daught	er	675 Roanoke S			
ře,	ges 1 and t of Health If item 27 or other to		20a. Method of Disposition 20b. Place of I	Dispo	osition (Name of matory or other place)	Date 20	c. Location - Cit	ty or Town, State
Ĕ	Pages nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Spesu	tia	Church Cemetery	8/14/04	Perry	man, MD
Balti	permit. Page Department Important: If any injury o		21. Signature of Fund if Sedric Coensee	L 22	Name and Address of Facility Lemmon Funeral Ho W. Padonia Rd.	ome of Du	laney \	Valley, Inc.
	45		23a. Part. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot ent	er the mode of dying, such as cardiac	or respiratory arrest	·	Approximate Interval Between
	Physician		Immediate Cause (Final	1	HEADT F.	ALIJIRE		Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of	 f):	112/11/	110010		
	Examiner		ISCHEMIC		HEART DL.	SEASE		
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	f):				
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of	ο.				
, 0	cate be executed physician and the burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of	1).				
8760,	ate b	dical	d					
9	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of	of delivery
Вох	atten for us	lan	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month	-
P.O.	the de	ysic	1 Yes 2 12 No 9 Unknown					
	res that t signed by be deta		Part II. Other significant conditions contributing to death but not resulting in	the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribu	ute to the cause of death?
sp.	uires 1 sigr Ild be	d by	Hypertension			1 🗹 Yes	2 □ No 3	☐ Probably 4 ☐Unknown
00	w require been signal	Completed	COPD			24a. Was an	/ 24b. We	re autopsy findings available
Re	he lav e has age 2	mc				autopsy performe	d dea	or to completion of cause of ath? Yes 2 \(\) No
la	ician: Th certificate rector, paç	CO	25. Was case referred to medical		26 Place Pea	ith Check on one	No 1L	1165 2 10
5	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	patie	Other	lome 5 Residence	e 6 Other	(Specify)
10			27. Manner of Death 28a. Date of Injury 28b. Ti	me o	of 28c. Injury at Work?	28d. Describe how	injury occurred	
ion	Attending F ir death. ector: After by the funer	atlo	1 12 Natural 5 □ Pending (Month, Day Year) In 2 □ Accident investigation	1017	M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Attendate death	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, st	reet, factory, office	28f. Location (Stree City or Town,	et and Number State)	or Rural Route Number,
	ital or A irs after ral Directed in by	Cer						
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 2 Madical Examinar: On the basis of examination and and manner stated.	deat Vor in	th occurred at the time, date and place ovestigation, in my opinion, death occu	, and due to the caustred at the time, date	se(s) and mann and place, and	er as stated. d due to the cause(s)
	thin 2 the 1 the 1 mplet	Med	one) and manner stated. 29b. Signatyre and title of certifier		29c. License number	290	Date signed (/	Month, Day, Year)
	To Too		BALLALA CALANI. V.	43	D 7 7 7 7 9 9	2	8/12	12014
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print		0/10	1007
1	Û		BARBARA CARROUL, M. D.	. , , ,	13801 VORK	R.D. CA	CKEV	SILLLE MID
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 "	- 00 / 01 111	1 1	7.	1 1
	Regist		AUG 1 7 2004 Series 19	A	oaks			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death I. Decedent's Name (First, Middle, Last) Day Vasi 16, Bessie Anna Muenzing 2004 1:00 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Riverview Nursing Center Esseex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 1 □ M 2 🖾 F 91 Yrs. 212 10 5380 Sept. 21, 1912 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Essex Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 309 Townsend Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 ▼Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Mfg. Sewing Machine Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Josephine Vlasek Charles James Vrany 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 804 Virginia Avenue Baltimore, Maryland 21221 Alice Metz (PersonalRep.) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland Greenmount Crematory 8/17/2004 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Atrial Due to (or as a consequence of teoperes IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐ Yes 2X No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2X No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred

Examiner requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospitel or Attending

Physician

/Medical

Examiner

Funeral

Director

in than "neturel", or Items 23s or 28e-f show the Medical Examiner must be notified at

al Hygiene.

2 should be f and Mental I is marked

Pages 1 and 2

Health item 27 i

permit. Pages 1 Department of H Importent: If ite eny injury or otl once.

Physician

/Medical

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the attending physician

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After this

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24 hours a

To the

death.

use as the burial-transit

Director

Funeral

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Completed

2

Examiner

Physician/Medical

2

Certification:

Medical

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

29a. Certifier

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 7 2004 AUG 1

29b. Signature(and title of certifier

Sebastion

5 Pending

investigation

6 Could not be determined

JOLA 3023 Caltern 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thenne

1 ☐ Yes 2 ☐ No

D 0055171

Baltmore

TC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:05 AM 2004 Harold Leo McAnaugh August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Laurel Regional Laurel Prince George's 5. Social Security Number 6. Sex XXM 2□ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Min. Months Hours Director 024-16-4796 Yrs. 81 28. 1922 Massachusetts Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City, Town or Location 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Coventry RT Kent 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ō 332 Town Farm Road Itams 23e 02816 USA death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 □ No 1943 − If Yes, Give Year or Dates: 1946 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "netural", or Itar 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Manager Lumber Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward McAnaugh ျှ Bertha Benoit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean P. McAnaugh/Wife 332 Town Farm Road, Coventry, RI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Highland Memorial Pk 8/16/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Johnston, RI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 00 CM01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mona disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 ☐ Probably 4 XUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? certificate 1 Yes 1 Yes 2 🔀 No 2[XNo the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To 1 Inpatient 2€R/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laurel Regional Hospital, Emergency Dept Henry S. Willner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

			1 - For State Registrar		aryland /		artment of H tificate of I		and M		giene No/2	004	2571.1.
	Physici /Medic		Decedent's Name (First, Middle, Donald L	Last)	MacGil	L1iva	ary			2. Date of Dea Month August	Day	2004	3. Time of Death 6:10 A _M
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, or Rockvi	11e			4c. Co Mo	unty of Dear	
	Funeral Director		5. Social Security Number 226 - 42 - 0374 Usual Residence of Decedent	. Sex 7. Ag	ge (In yrs. last I 72	birthday) Yrs.	If Under 1 Year Months Days	If Under :	Min	8. Date of Birth (Month, Day June 21	Year) 193	9. Bird Co No	thplace (State or Foreign buntry) DVA Scotia
	Maryland a-f show	tor	10a. State 10b. County	gomery	10c. City, To Kens	own or Lo							10d. Inside City Limits 1 ☐ Yes 2 XNo
	ith with the 23a or 28	al Director	10e. Street and Number 3216 Edgewood 1	Road			10f. Zip Code	2089	5	1	10g. Citizer Can	of What Co	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic event, the Medical Evantral retroubled. It office.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1	,		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛛 No	ispanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	ncan Indian, e, etc. Vhite
Maryland 21215-0036	s within 72 ho plene. r than "natui the Medical	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Airline Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle,							g Airlines			
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	and 2 sh ealth and m 27 la m	0 1	17. Father's Name (First, Middle, Last) Daniel Joseph MacGillivary 18. Mother's Name (First, Middle, Mai Ellen McKeagen 19a. Informant's Name/Relationship (Type, Print) George N. Vassilas (Nephew) 19b. Mailing Address (Street and Number or Rural Route Number, Compaction of the Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Terminatory or other place) August 13,										
Baltimore,	Pages 1 ment of H ant: If iter ury or oth		Airline Services Beltsvilline Services Airline										Town, State
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lie	Shoody M	01261	22	Name and Addres Rapp Fund 933 Gist	eral Ave.	and , Si	Crematio 1ver Sp	on Ser	rvices Md. 2	0910
	Pnysician		Immediate Cause (Final disease or condition						cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a										
8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, lary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						-			_
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s, P	sign sign d be												the cause of death?
Vital Record	The faw ate has b page 2 si	Completed								24a. Was all autops perform	y	b. Were au prior to c death? 1 \(\text{Yes}	topsy findings available ompletion of cause of
The second of th								Hospice					
Dİ	ital or Attend urs after death ral Director: /		4 Homicide determine	ed 28e. Place of Inj building, et	c. (Specify)					City or Town	i, State)		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one) Z Medical Ex	Physician: To the best aminer: On the basis o and manner st	r examination a	ge, death and/or inv	estigation, in my op	oinion, death	i place, a h occurre	ed at the time, da	ate and pla	ce, and due	to the cause(s)
)	wil To		29b. Signature and title of certifier	the			29c. License	112	18	2	81	12/	OH
	V		30. Name and address of person where Charles Harriso)(Type, I LCast	er Mill I	Rd., I	Rocky	ville, M	id. 20	855	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 200		ar's Signature	1	porks						

			1 - For State Registrar	-			nd / Depa	artment of rtificate of	Health a		ntal Hyg	_	n I	the transit to have
			Decedent's Name (First, M.	liddle, La	st)			imouto or	Douth	2	. Date of Deat	1.00	1	3. Time of Déath
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	/Medi Exami		4a. Facility Name (If not instit	ution. aiv				4b. City, Town,	or Location of		ugust	12, 20 4c. County	04 of Death	7:52 A M
1	Exami	ie:					Jonton	Baltir		o caur		70. 000	OI DOMIN	
	Funeral		Johns Hopkins 5. Social Security Number	6.3	ex	7. Age (In yrs.	last birthday)			4 Hrs. 8	. Date of Birth		9 Birthr	place (State or Foreign
	Director		219-28-8408		1₽M 2□F		71 Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day,	1932	Coui	rland
	D		Usual Residence of Deceden	t			,		_1		-pc. 4)	1732	LIMI	rand
	rylan how	١.	10a. State 10b. Col	inty		10c. Cit	ty, Town or Lo	cation					1	0d. Inside City Limits
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	th th	ire	10e. Street and Number					10f. Zip Code			1	0g. Citizen of	What Cour	ntry?
	15 wi	ai	6204 Baker Ci	$rcl\epsilon$	e, Apt.	E		21040)			USA		
	dea Bms	ner	11. Marital Status		12. Was Dec Armed Fo	edent Ever in U	.S. 13.	Was Decedent of f Yes, specify Cui	Hispanic Origi	in? (Specif	y Yes or No-	14. Rac	e - Americ	an Indian,
9	or It	F	1 Never Married 2		1 X Yes If Yes, Gi		1	1 □ Yes 2 ☑ No		rueno nic	an, etc.)		ck, White,	
8	ural',	d b	3 ₩idowed 4 □ Divo	ced	Year or D	ates:						Specin	Whit	:e
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Itams 23a or 28a-f show the Madical Examiner must be notified at	Completed by Funeral Director	15. Dece (Specify only hi	dent's E	ducation ade completed)		16a. Dece (Give	dent's Usual Occu kind of work done DO NOT use retire	ipation during most o	of working		16b. Kind of B		
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3	should nd Men marke umatic	To	Anthony Jose			i			1		bara D			
Maryland	12 sho		19a. Informant's Name/Relat	ionsnip (Type, Print)			ig Address (Stree						
	1 and 2 Health tam 27 I		Thomas Messir 20a. Method of Disposition	ıa –	Son	20h E	1413	St. Chr	<u>istophe</u>	er Ct.	, Edge	wood,	Maryl	and 21040 wn, State
ō	Pages 'nent of Hant: If its		Burial 2 Cremati	on 3 🗆	Removal from	State C	æmetery, crer	natory or otner pi	1Ce)					
Ë	tmen tant:		4 □Donation 5 □ Othe			Dul		alley Me				'imoniu	m, Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic avant, tre Medical Examiner outst be notified at once.		21. Signature of Funeral Serv	rice Lice	1See		Mc	Name and Addr COMAS	uneral	. Home	P.A.			
	707 a 0		May 1140	mas	Ken	y h	<u>> 13</u>	17 Cokes	sbury R	d A	binado	n, Mar	yland	21009
			23a. Part1. Enter the disease shock, or feart failure.	, or com List only	plications that one cause on e	aused the deat each line.	h. Do not ent	er the mode of dy	ing, such as ca	ardiac or re	espiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		2 M-	cerdi.	~ /	Infan	hon					i hour
	/Medical Examiner		resulting in death)		Due to	(or as a conseq	uence of):	Infan.						1 -(00)-
	Examine	Ļ	Sequentially list conditions.	- 1	b. Co	ronary	. A.	teny	Direc	56				5 Years
	₽ .≓	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	Due to	(or as a conséq	uence of):	,						
	and trans	am	that initiated events resulting in death) Last	1	c									
760,	ate be executed hysician and the burial-transit	Ē	reconning in death, East		Due to	(or as a conseq	uence of):							
876	ate b	licai		•	d									
K 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE:											
Box	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		1 🗆 Live b	come of pregna oirth 2 Feta	I death 3	Ectopic pregnanc	y			23d. Dat	e of delive	. ,
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregr 9□ Unkn	ant at time of down	eath 5□	Other (specify) _				IVIO	itti	Day Year
P.0	res that the de igned by the a be detached t	Ph)	Part II. Other significant con-	ditions		and but and and	- 161 1 - st				00 5			
Ś	res the	by						iderlying cause gr	ven in Part I.					e cause of death?
0.0	w require been sig should b	ted	Congern	re	hecu r	44110	116				Yes	3 2 ∐ No	3 ∐ Proba	ably 4 Unknown
Records,	e law has b	Completed by	Respira	ton	y Fa	ilura					24a. Was an autopsy	24b. V	Vere autop	osy findings available
H		Son	,		,						perform	ed?	leath?	
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to med examiner?	lical					26. Place of	f Death (C	heck only one			
Ť.	Shysic this co	^o L	1 ☐ Yes 2 No		Hospital: 1 □ I	npatient 2	ER/Outpatien	3□ DOA Ct	her: 4 Nursi	ing Home	5 Resider	ice 6 Othe	er (Specify)
ם	ding Ph h. After th funeral	:uo	27. Manner of Death Natural 5 ☐ Per	ndina	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d	. Describe how	v injury occurr	ed	
Division	andi sath. or: A he fu	Certification;	2 ☐ Accident inv	estigation	1			M 1	Yes 2 □ No	0				
≅	r Att ter d irect	tiff		uld not be ermined	28e. Place	of Injury - At ho	ome, farm, stre	et, factory, office		28f.	Location (Stre City or Town,	et and Numbe State)	er or Rural	Route Number,
0	ital o													
	losp hou una una sly fil	edicai	29a. Certifier Certi	fying Ph	ysician: To the	best of my kno	wledge, death	occurred at the ti estigation, in my	me, date and p	place, and	due to the cau	use(s) and ma	nner as sta	ited.
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	ledi			and man	ner stated.		oougaton, in my (Apimon, death	occurred a	at the time, dat	e and place, a	ina aue to	une cause(s)
	To I To I	Σ	29b. Signature and little of cer	tifier	//	1		29c. Licens			29	d. Date signed		Pay, Year)
				11	Pour	w	(Ani		3386		ļ	8113	-	
l-	11		30. Name and address of pers			e of death (Item	23a) (Type, I	Print)						21201
J_{ν}	r,		Daniel	R.	10	buard		D 82	IN. E	Putar	· 4405	- Bu	26/2	21201 ur mo
	Sta		31. Date filed (Month, Day, Ye	ear)	32. A	egistrar's Signa	ture	,						,
	Registi	rar	AUG 1 7 2	2004	Sen	wa	19 1	park						

				partment of Health and ertificate of Death	-	ne 2004	25716
	Dhysie		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physic /Medi		Angelo M. Napoli		AUĞÜST 1	Day Year 3, 20014	10:00 FM
	Examir	ner	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center	4b. City, Town, or Location of Dea	on	4c. County of Death Balt	imore
	Funeral Director		5. Social Security Number 218-05-6911 6. Sex 1 M 2 F 7. Age (In yrs. last birthdi	Months Days Hours Mir		ar) 9. Birtl Col 1921 Neu	hplace (State or Foreign untry) W YORK
	/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	a-f sh	ctor	Maryland Baltimore	Baltimore			1 ☐ Yes 2 💢 No
	ith the)ire	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cor	untry?
	s 23e	rai	4102 Taylor Avenue	21236		u.s.A.	
980	be filed within 72 hours after death with the Maryland hal Hyglene. Id other than "naturel", or Items 23e or 28e-1 show event, if e Marifall Examination and items are notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 ☑ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puet 1 Yes 2 No Specify: 	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
5-0	"natu	letec	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of w b. DO NOT use retired)	orking 16b	. Kind of Business/l	ndustry
12	withir ene. than	Completed by	College (1-40r 5+)	s. DO NOT use retired) Echanic	1	Delivery	
102	i Hygi other	Be Co	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid		
ylar	Menta Menta arked atic ev	To B	Michael Napoli	Josep	phine 1	Lazzaro	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 'Health and Mental Hygiene. tem 27 Is marked other than "tother treumatic event, It e Market and the treumatic event, It e Market and the treumatic event, It e Market and the treumatic event, It e Market and the treumatic event, It e Market and the treumatic event, It e Market and the treumatic event, It e Market and the treumatic event, It e Market and the treumatic event.			illing Address <i>(Street and Number or F</i> 13 Boston Avenue,			îp Code)
ore	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Discemetery, comments of the commen	sposition (Name of rematory or other place)	Date 20c.	Location - City or T	Town, State
Itim	rtmen rtent: njury		*4 □ Donation 5 □ Other (Specify) Parkwoo 21. Signatuy of Juneral Sprvice Licensee ↑	d Cemetery 8/1	8/2004 Ba	ltimore,	Maryland
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		· (Brishne & Dawid	22. Name and Address of Facility Son 9705 Belair Rd.,	Baltimore,		1es
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final			general unique a g gamba	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. METASTATIC NON Due to (or as a consequence of):	-SMALL CELL CHI	KCINUMA U	- IHE	
	Examiner		Sequentially list conditions.	IVER, BONE, ANI	D BRAIN		
	ped isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that invitable and the property of the control o				
	al-trar	Examiner	that initiated events resulting in death) Last c. ACUTE RENAL FA Due to (or as a consequence of):	ILURE			
8760,	icate be executed physician and the burial-transit	dicai E	d				
9	ntifical ng ph	l du ⊦	IF FEMALE:				
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	B ☐ Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	r ery Day Year
ls, P	es tha gned be de	by	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	11	o use contribute to t	
Ö	w requir been si should	eted				2 No 3 Prot	bably 4 □Unknown
al Records,	The larate has	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital		o Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital: 1 Alignation: 2 TSR/Outpati	Oth on	ath (Check only one)		-
on of	ding h. After fune	H	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ EP/Outpatient 2 ☐ EP/Outpa	of 28c. Injury at	Home 5 Residence 28d. Describe how inj		fy)
Division	of or Attendie after death. I Director: Al d in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rura ite)	al Route Number,
	Hospite 24 hours Funere	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Exeminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occi	e, and due to the cause(urred at the time, date a	(s) and manner as s nd place, and due to	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of pertifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
			· Walls mi)	D 25886		Gugust	- 14-2004
11			30. Name and address of person who completed cause of death (Item 23a) (Type	a, Print)		- 0	
V	-04		TITA CEBALLOS, M. D. 76/21 OSL 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ER DRIVE, TOWSO	ON, MARYLA	AND 2120	14
	Sta Registr	_		line de			

			1 - For State Registrar	State of Mar		ertificate of			iene •g. No2 () () L	2571.7
	° Physici /Medio		1. Decedent's Name (First, Middle, Last) Francis P.	Nugent				2. Date of Deat Month August	15, 2004	3. Time of Death 2:05 PM
	Examir	er	4a. Facility Name (If not institution, give s Paradise Assi 5. Social Security Number 6. Sex	isted Livi	ng (In yrs. last birthday		r Location of Dea nsville			ltimore
	Funeral Director		579-10-5944 X- Usual Residence of Decedent]M 2□F	87 Yrs.	Months Days	Hours Mir		1917 C	Birthplace (State or Foreign Country/District Of Olumbia
	ih ihe Marylar or 28a-f show e natified at	Director	Maryland Baltimon 10e. Street and Number	re	10c. City, Town or L Catons	ville 10f. Zip Code		1	0g. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2√ No Country?
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumatic event, the Madical Examinar must be natified at once.	by Funeral [6348 Frederick I	Road 12. Was Decedent Ev Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 4.		21228 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	USA 14. Race - Ai Black, W Specify: W	
Baltimore, Maryland 21215-0036	ed within 72 hou giene. er then "nature i, the Madical E.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dec (Giv	edent's Usual Occup e kind of work done DO NOT use retired Plastere	during most of wi	orking	16b. Kind of Busines	
yland	ould be file I Mental Hy narked oth natic event,	To Be (17. Father's Name (First, Middle, Last) Patrick Joseph Nu	9			Ros	ame (First, Middle, M se Ann Da]	Lton	,
ore, Maı	es 1 and 2 st of Health and If item 27 is n or other treun		19a. Informant's Name/Relationship (Ty. M. Therese Love/dau 20a. Method of Disposition 1 □ Burial 2 【XCremation 3 □ R	ughter	601	Plymouth position (Name of amatory or other place	Road I	Baltimore Date		1 21229
Baltim	permit. Peg Department Importent: eny injury c once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service □ ense Thomas Gregor □		1 2	ematory I	ss of Facility	.6/04 Of Maryla l Baltimor		e,Maryland
)	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heartfailure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Athen	osclerot	nter the mode of dyin	ig, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a o	consequence of): consequence of): consequence of):					0
.O. Box 687	eath certif attending for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	□Ectopic pregnancy	1		23d. Date of d Month	lelivery Day Year
<u>α</u>	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the	underlying cause give	en in Part I.	23e. Did tob	1	to the cause of death? Probably 4 □Unknown
al Records,	The law ate has b page 2 sl	Completed						24a. Was ar autops perform 1 Yes 2	/ prior to	
sion of Vital	d s	ation; To Be	27. Manner of Death 1	1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time	of 28c, Injury Work	er: 4 🗆 Nursing	eath (Check only one Home 5 Reside 28d. Describe ho	nce 6 Other (Sp	Assisted Living
Division	pitel or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.				City or Town	, State)	Rural Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Fur arel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 □ Certifying Phys 2 □ Medical Examin 29b. Signature and title of certifier	sician: To the best of ener: On the basis of eand manner state	xamination and/or i	vestigation, in my o	pinion, death occ	urred at the time, da	te and place, and di	ue to the cause(s)
	0	ta	30. Name and address of pers. who co	Fr APITIE	Sec. 15.	, Print)	241	timesey.	11 212	29
:	Sta Registi		AUG 1 7 2004	32/ Registrar's	19	sparks				

			1 - For State Registrar	State of N	Maryland			t of H	ealth a		_		2001	. 2	5748
	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Da	ıy Yea		Time of Death
-	/Medi		Eva Constanc							7	August				0:37PM
1	Examir	er	4a. Fecility Name (If not institution,				4b. City,		Location of			40	. County of De	eth	
	7		Johns Hopkin 5. Social Security Number			- 4 h (-4h -41)	If Under		timo:						
	Funeral Director		212–09–1905 Usual Residence of Decedent	1□ M 21 7 F	Age (in yrs. la:	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da August	y, Year	913 Mai	lirthplece (Country) rylan	State or Foreign
	nylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. In	side City Limits
	e Ma	ctol	Maryland		Balt	imore	9							1	Yes 2 No
	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other than "netural", or iteme 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	1300 South Ellw	ood Avenue			10f. Zip 212	Code 224					nited S	,	s
	teme	une	11. Marital Status	12. Was Deceder Armed Force			Was Deced	ent of His	spanic Origi n, Mexican,	in? (Spe	cify Yes or No	-	14. Race - An Black, Wi	nerican Inc	lian,
36	s afte	y F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	No		I□Yes 2		Specify:						
21215-0036	tural teral	d be	15. Decedent's	Year or Dates	3:								Specify: Wh		
5	in 72 n n n	piet	(Specify only highest	grade completed)		16a. Deced (Give	lent's Usua kind of wor DO NOT us	i Occupa k done di e retired)	tion uring most i	of workin	g	16b. K	and of Busines	s/industry	
212	with prene.	omi	Elementary/Secondary (0-12)	College (1-4o	or 5+)	Fact		- / 0100/					Paper		
פ	other	Bec	17. Father's Name (First, Middle, La	ist)					18. Mother	's Name	(First, Middle,				
<u>lar</u>	Vents Vents rked rife e	To E	Michael Marski						Anna	Nado	olny				
Maryland	2 should be a named of is marked or raumatic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a				er, City	or Town, State,	Zip Code)
	1 and 2 Health em 27		Patrick Siemek -	Nephew				400	Road,	Pasa	adena,	Mar	yland 2	21122	
ore	Fite or oth		20a. Method of Disposition 1 Table Burial 2 Cremation 3	☐Removal from Stat		ce of Dispos netery, crem	sition (Nam natory or oti	e of her place)	Da	ate	20c. L	ocation - City o	r Town, Si	ate
ΕÏ	Pag tment tant: jury		'4 □Donation 5 □ Other (Spe			Stan	islaus	s Cer	netery	y 8/	18/03 E	alt	imore,	Mary.	land
Baltimore,	permit. Pages 1 an Department of Heat Important: If item 2 eny injury or other 2005.		21. Signature of Funeral Service Lie	a. We	bush		Name and			Fune:	ral Hon	nes,	P.A. timore,	212: Mar	31 yland
			23a. Pert1. Enter the disease, or co shock, or heart failure. List or	implications that causiny one cause on each	ed the death. line.	Do not ente	r the mode	of dying	, such as ca	ardiac or	respiratory ar	rest,	- LIIKAL C.	Appro	oximate al Between
	Physician		Immediate Cause (Final disease or condition		2.	203	(Onse	t and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequer	nce of):								1	D Noy
	Lxummer	_	Sequentially list conditions,	b	7/20	WE	(.VA							
	ed set	Jine	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20910 (378	is a conseque	nus of).									
	al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a consequer	nce of):				-		-			
760,	ate be executed hysician and the burial-transit														
687	tificate ng phy: as the	edic		d										-	
Вох	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date of de	disons	
	death e atte	Icia	in the past 12 months? 1 Yes 2 Selvo	4 Pregnant	2 Fetal de at time of deat		Ectopic pre Other (spe						Month	Day	Year
о. О	t the de by the a tached t	hys	9 □ Unknown	9∐ Unknown											
	as tha	by P	Part II. Other significant conditions		but not resulting	ng in the un	derlying ca	use giver	in Part I.		23a. Did to	bacco u	ise contribute t	o the caus	e of death?
ğ	w require been sig should b		DEMENT	24							1 □ Y	es 2	X 040 3□P	robably	4 Unknown
Records,	law r as be	Completed	Clospaidin	D. Sticolia	MRS	A					24a. Was a		24b. Were a	utopsy find	lings available
_		Con			,						autop: perfor	sy med? 2.⊠No	death?	completion s 2□No	n of cause of
<u>ita</u>	ysician: Th	Be	25. Was case referred to medical examiner?								Check only or	10)	1		
Division of Vital	Physic this c	2	1 Yes 2 No	Hospital: 1 ☐ Inpat		VOutpatient		Other	4 🗆 Nursi	ing Home	e 5 🗆 Resid	ence (Other (Spe	ecify)	
ב	ding f h. After funer	lon	27. Manner of Death Watural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year) 28	3b. Time of Injury		c. Injury a Work?	ıt	28	d. Describe h	ow injur	y occurred		
<u>S</u>	death. ctor: A / the fu	Certification:	2 Accident investigat 3 Suicide 6 Could not	be 300 Bloom of to	nium. At hama		М		ıs 2⊡No						
2	or A after Direct	ertif	4 Homicide determine	28e. Place of Ir building, e	atc. (Specify)	e, rarm, stre	et, factory,	office		28	If Location (5) City or Tow	treet an n, State	d Number or R)	ural Route	Number,
	To the Hospitel or Attending Physician: whim 24 hours after death as the this certifica. To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 12 Certifying	Physician: To the bes	t of my knowle	edge, death	occurred at	the time	date and r	nlace an	d due to the c	auco(c)	and manoer a	c ctated	
	n 24 i	Medical	(Check only 2 ☐ Medical Ex	aminer: On the basis and manner s	or examination	and/or inve	estigation, in	n my opir	nion, death	occurred	at the time, d	ate and	place, and due	o to the car	use(s)
	To the within 2 To the	Σ	29b. Signature and title of certifier				29c.	License r	number		2	9d. Dat	e signed (Mon	th, Day, Ye	ear)
				~ W>				0	242	76	,	4	160	7	
			30. Name and address of person wh		death (Item 23	3a) (Type, P	rint)								
1			Smu S	LALIA	w										
	Sta Registra	-	31. Date filed (Month, Day, Year) NIG 1 7 2004	32. Regist	trar's Signature	Se	parks								

			1- For Amend Item #8 State of Maryland / Der Ragistrar	Partment of Health and Mental ertificate of Death	Hygiene	2571.0			
	D		Decedent's Name (First, Middle, Last)	2. Date of Month	f Death	3. Time of Death			
	Physici /Medio		ELIZABETH	NOEHOVICI AUGUS	T 14 2004	12:14 P ^M			
	Examir	ier	4a. Facility Name (If not institution, give street and number) 406 SHIRLEY MANOR ROAD APT. B-1	4b. City, Town, or Location of Death REISTERSTOWN	4c. County of De.	E			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda. 212-17-2119 1 M 2 F 80 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. 1 (Months)	f Birth 1/12/1924 1. Pay (1941)	irthplace (State or Foreign			
	Director		212-17-2119 1 M 3 F 80 Yrs. Usual Residence of Decedent	12/12	72004	AUSTRIA			
	nyland how		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits			
	Be-f s	Director	MD BALTIMORE REISTERST	OWN		1 □ Yes 2 No			
	with th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?			
	ns 23	Funeral	406 SHIRLEY MANOR ROAD APT. B-1 11. Marital Status 12. Was Decedent Ever in U.S. 13	21136 Was Decedent of Hispanic Origin? (Specify Yes o	U.S.A. 14. Race - Am	neocan Indian			
36	72 hours after death with the Maryland natural', or items 23s or 28e-f show lical Examination at the modified at	y Fur	1 ☐ Never Married 2 1 ☐ Yes 2 1 No	 Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc		iite, etc.			
21215-0036	n 72 hours "natural", ulcal Exe	ed by	3 Wildowed 4 Divorced Year or Dates:	^	Specify: WH				
215	within 72 ene. than "na	piet	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Busines:	s/industry			
	ed will ygjene yer tha	Completed	4 CHEM	IICAL ENGINEER	RESEARCH I	NSTITUTE			
Maryland	ges 1 and 2 should be filed within 72 hi t of Health and Mental Hyglene. If item 27 is marked other than "natu or other traumatic svent, Ite Medical	Be	17. Father's Name (First, Middle, Last) MARTIN MENDROCH	18. Mother's Name (First, Mi		KNOWN			
ary	should nd Men marke umatic	P		ling Address (Street and Number or Rural Route N					
	ss 1 and 2 of Health a litem 27 is r other trai			HIRLEY MANOR RD. APT B-					
Baltimore,	permit. Pages 1. Department of He Important: if iten any injury or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 1 ★ □ Donation 5 □ Other (Specify)	position (Name of Date	20c. Location - City o	r Town State			
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL LEVI	NSON & BROS. PIKESVILLE.	, INC. MD 21208			
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirato		Approximate Interval Between Onset and Death			
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hend Frilare		3411			
1	Examiner		Due to (or as a consequence of):						
	ν π	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease tripury						
_	and and Il-trans	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last						
8760,	ate be executed thysician and the burial-transit	dicai E	d						
9	rtificat ng phy as the	Medic							
Вох	leath certific attending p I for use as	lan/N		☐Ectopic pregnancy	23d. Date of de Month				
P.O. F	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Day Year			
	res that i igned by be deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. [Did tobacco use contribute t	to the cause of death?			
ords	w require been sig should b	ted b			□Yes 2⊡√No 3□P	Probably 4 □Unknown			
Records,	e 2 sh	Completed by		a	Vas an 24b. Were a prior to	autopsy findings available completion of cause of			
a	Phyaiclan: The law this certificate has b al director, page 2 s		26 Was associated to making	1 □ Y	es 2 1 1 Ye				
' Vital	Phyaiclan: this certific al director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death Check of Death C		agifu)			
n of		O 1 Yes 2 No							
sio	Attending r death. actor: After by the fune	catio	2 Accident investigation	M 1 Yes 2 No					
Division	after of Diraci	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location City on	on (Street and Number or R Town, State)	Rural Route Number,			
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the control of the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to investigation, in my opinion, death occurred at the ti	the cause(s) and manner a ne, date and place, and du	s stated. e to the cause(s)			
	To the within To the comp		29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)			
			Marche d. 11 ws. pr. 1)	101544	8/17/-	07			
3			30. Name and address of person who completed cause of death (Item 23a) (Type Role-+ L. Mori 114 Bris	ners Confor Dr. R	eisterston	o, Ml			
	Sta Registi	ate	31. Date filed (Month, Day, Year) 32. Registrar's 3 ignature AUG 1 7 2004	K					

			101	partment of Health and Nertificate of Death		giene	01.	25750	
T			Decedent's Name (First, Middle, Last)		2. Date of Dea	uth	U N	3. Time of Death	
	Physici /Medic		Alexey Neklud	ΟV	Month August	Day 12, 20	Year 04	10:24 PM	
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County	of Death		
1			Holy Cross Rehabilitation Center	Burtonsville		Montg	omer	У	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	(, Year)	Cour		
	Director		173-26-8578 12 M 2 P 92 Yrs. Usual Residence of Decedent		Feb 17	1912	Russ	sia	
	land ow		10a. State 10b. County 10c. City, Town or	ocation			1	0d. Inside City Limits	
	Mary -1 sh	to	MD Montgomery Burtons	ville				1 ☐ Yes 2 XNo	
	r 28a	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of V	Vhat Cour	ntry?	
	h with		3440 Oakhurst Drive	20866		U.S.A.			
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Rac		an Indian,	
350	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23e or 28e-f show says injury or other treumatic event, I'm Medical Erain and must be notified at anone.	by Fu	1 Never Married 2 Married 1 Tyes 2 N No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	Rican, etc.)		k, White, Whit		
9500-61212	2 hou	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Bu			
ני	hin 7: n "n Medi		(Specify only highest grade completed) (Ghiffe Elementary/Secondary (0·12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ring			,	
7	giene giene	No.		ineer		Electr	onic	5	
2	al Hy al Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam			ю)		
Maryland	Ment Ment arked	To	Alexander Nekludov	Eugenia	Serduko	V			
a	2 sh and Is m			ling Address (Street and Number or Rur	al Route Numbe	r, City or Town,	State, Zip	Code)	
 (1)	l and lealth im 27 her tu			Oakhurst Drive, I					
<u></u>	iges if of F if Ite or of		1 U Buriai 2 Deremation 3 U Hemoval from State	ematory or other place)	Date	20c. Location -	•		
galtimore,	t. Partmer			del Crematory Aug		Odentor	ı, Ma	ryland	
g	Depa Impo any is		Laure Warol dan M00160	22. Name and Address of Facility Donaldson Funeral I 313 Talbott Ave. La	Home, P. aurel, M	A. aryland	2070	07-4389	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arr	est,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition Polymyalgia Rhen	ımatica				Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):						
	Lamine	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					100	
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
	al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):						
8/60,	icate be executed physician and s the burial-transit	dicai	d						
g	ifficat g phy as the	0							
XOD	eath certific attending p i for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3		23d. Date	23d. Date of delivery			
	the death certificate be executed y the attending physician and iched for use as the burial-transit		1 Yes 2 No	2 □ No 4 □ Pregnant at time of death 5 □ Other (specify)					
cords, P.O.	d by t		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	-	OZ- Didas				
	law requires that the de as been signed by the 2 should be detached	d by	coronary heart disease	underlying cause given in Fatti.				e cause of death?	
	w requ	Completed			24a. Was a	n 24h W	Voro autor	sy findings available	
Ě	sicien: The law certificate has b irector, page 2 s	Jup			autops	med? p	rior to con eath?	npletion of cause of	
	en: T	e Cc	25. Was case referred to medical	26. Place of Deatl			☐ Yes	2 No	
	Physicien: this certific ral director,	0 0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	0.4	me 5 Reside		r (Specific)	
10	ding Phys th. : After this funeral dir	ıü.	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe ho			/	
DIVISION	teath. tor: Af the fur	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No					
Š	or Atter de Directe in by ti	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town		or or Rura	Route Number,	
	urs af urs af eral D	Cel							
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	ledicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	withi To the	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed	(Month, L	Day, Year)	
^			I Wan K Segal is	D52261		August	14,	2004	
1)		30. Name and address of person who completed cause of death (Item 23a) (Type	/	MD 2000	c			
1	Can	• 0	Alan R. Segal, M.D. 1517 Hugo Circl 31. Date filed (Month, Day, Year) 22. Registrar's Signatury	e, Silver Spring,	MD 2090	0			
	Sta Registr		AUG 1 7 2004	peur					

		1 - For State Registrar	State of Marylan	d / Dep		Health and I	Mental Hyg	_	25751	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) L, LL E PULL! AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death				2. Date of Deat Month	Day Ye	04 9:43 A M		
Funeral Director	er	HOWARD (UUNTY 6) 5. Social Security Number 217 - 12 - 66 06	6. Sex 7. Age (In yrs. last birthday) H Under 1 Year H Under 2					Hou		
death with the Maryland ms 23a or 28a-f show rmat be notified at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County HOWA 10e. Street and Number	RD)MZ(4		10	Og. Citizen of What	10d. Inside City Limits 1 Yes 2 No Country?	
ja 2 2					lispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) 14. Race Black,			merican Indian, /hite, etc.		
id within 72 giene. er than "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)				iduring most of word ad) MAKER	ing most of working		DOMESTIC	
nd 2 should be lith and Mental 27 is marked r traumatic ev	To Be								e, Zip Code) 21044	
permit. Pages 1 ar Department of Hea Important: If item 3 any injury or other once.		20a. Method of Disposition 1 Disposition 2 Cremation 3 Disposition 4 Donation 5 Other (Specify 21. Signature of Fundal Service Licen)	NOOE	osition (Name of matory or other place) Awww. Name and Adde	ass of Facility	17.04		AWN, MD	
Fnysician /Medical Examiner onvial-transit	cai Examiner	23a. Part1. Enlarde disease, or compshock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Preum Co Due to (or as a conseq C. Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq	uence of): VE F) uence of):	ter the mode of dy	ng, such as cardiac			Approximate Interval Between Onset and Death	
The law requires that the death certificate te has been signed by the attending physicage 2 should be detached for use as the I	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown						23d. Date of delivery Month Day Year		
he law requires that the has been signed by	ted by Ph							I tobacco use contribute to the cause of death? Yes 2 PNo 3 Probably 4 Unknown		
ician: The law i	e Completed by	25. Was case referred to medical				26 Place of Dea	24a. Was an autopsy perform 1 Yes 2	ed? prior death	autopsy findings available o completion of cause of ? es 2 No	
Attending Physic actor: After this by the funeral di	Certification: To B	examiner? 1 Yes 2 No Hospital: 1 Propatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other						nce 6 Other (S w injury occurred		
To the Hospital or within 24 hours afte to the Funeral Discompletely filled in	Medical Ce	29a. Certifier (Check only (Check only and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	A	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 29d. Date signed (Month 31. Date filed (Month, Day, Year) 32. Registrar (Signature pouls)						onth, Day, Year)		
Sta	ite ar	Kauser Amur I. 31. Date filed (Month, Day, Year)	hmad. 107 32. Registrar Bigna	24 l	title Pa	fanent	Parku	ony Colu	mbia MD 2100	

		State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #8 PER FH G834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death 3. Time of Death
Physici /Medic Examir	cal	Edwin Lyle Pitt 2. Date of Death Month Day Year AUGUST 15, 2004 6:55 AM 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Baltimore
Funeral Director		5. Social Security Number 217-07-0233 Usual Residence of Decedent 10b. County 10c. City, Town or Location 6. Sex
h the Maryla rr 28a-f shov	Irector	MD Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Macical Examinar must be notified. once.	To Be Completed by Funeral Director	2205 Foxley Rd. 21093 USA 11. Marital Status 1
Maryland 21218 of 2 should be filed within 7 ifth and Mental Hygiene. 77 is markad other than 71 traumatic evant, the Mary		(Give kind of work done during most of working life. DO NOT use retired) Selementary/Secondary (0-12) 9 17. Father's Name (First, Middle, Last) Clyde H. Pitt (Give kind of work done during most of working life. DO NOT use retired) Flectrical Engineer 18. Mother's Name (First, Middle, Maiden Sumame) Jennie G. Sipes
e, Mary 1 and 2 sho Health and N em 27 is ma		19a. Informant's Name/Relationship (Type, Print) Dottie Pitt/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Foxley Rd., Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Output Code)
Baltimore, permit. Pages 1 a Department of Hee Important: If Item any Injury or otha		1 Burial 2 Cremation 3 Removal from State 14 Donation 5 Other (Specify) 21. Signature of Funeral Service Librarsee 22. Name and Address of Facility
68760, ifficate be executed Examiner and as the burial-transit	edical Examiner	Michael Plagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Approximate Interval Between Onset and Death Onset and Death Due to (or as a consequence of): FINEUMONIA Due to (or as a consequence of): C. Due to (or as a consequence of): d
LO. BOX 68 at the death certifice by the attending pt tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
HeCords, P. The law requires that te has been signed by age 2 should be deta	Completed by Pf	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER DEMENTIA 23e. Did tobacco use contribute to the cause of death? 1
on of Vital ding Physician: 1 n. After this certifical funeral director, p.	Certification; To Be Con	25. Was case referred to medical examiner? 1 Yes 2X No 1 Yes 2X No 26. Place of Death (Check only one) Hospital: 1 Injury of Month, Day Year) 27. Manner of Death 1 Injury (Month, Day Year) 28. Date of Injury of Injury of Month, Day Year) 28. Injury at Work? 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No 28. Injury at Work? 1 Yes 2 No
DIVISION To the Hospital or Attantwithin 24 hours after death To the Funaral Director: completely filled in by the	Medical Certifi	4 Homicide determined 288. Place of Injury - At nome, farm, street, factory, office 281. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)
Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOBINDER F'. MEHTA. M. D. 76011 OSLER DRIVE, TOWSON, MARYLAND 212014 31. Date filled (Month, Day, Year) AUG 17 2004 AUG 17 2004

		1 - For State Registrar		Maryland / Dep Ce	partment of F			Reg. No. 0 0 4	25753
Phys		1. Decedent's Name (First, Middle, Leroy Harry I	,				2. Date of D Month August	Day Year	3. Time of Death 5:00 P. M
	dical niner	4a. Facility Name (If not institution, 605 Marshall Ro	-	r)	4b. City, Town, o		f Death	4c. County of Death)
Funer	al	5. Social Security Number 6	5. Sex 7. /	Age (In yrs. last birthda		If Under 2	24 Hrs. 8. Date of Bi	Anne Art	place (State or Foreign
Direct	or	216-14-8049 Usual Residence of Decedent	1₹M 2□F	82 Yrs.	Months Days	Hours	Mar. 18	y 1922 Mary	Land
aryland ahow	_	10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
r 28a-f	Director	Maryland Anne	Arundel	Glen	Burnie 10f. Zip Code	-		10g. Citizen of What Co.	1 Tyes 2 No
ath with	raiD	605 Marshall Ro			21061			United Sta	
ife, INTALYIATION A LAIS INTO SO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le marked othar than "natural", or Itams 23s or 28a-f ahow othar traumatic evant, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force d 12 Yes 2 If Yes, Give Year or Dates	s? 1942- 1946	: Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 № No		jin? (Specify Yes or N , Puerto Rican, etc.)		
c 1 3-U ithin 72 ho le. len "netur medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)	edent's Usual Occup re kind of work done of DO NOT use retired	during most d)	of working	16b. Kind of Business/l	ndustry
filed w Hygier Stharth	So	12 17. Father's Name (First, Middle, Li	ast)	Maga	zine Edito		r's Name (First, Middle	Insurance	2
yldil buid be Mental arked c	To Be	Harry Powell					Dennis		
d 2 d 2 d 2 d 2 d 4 d 4 d 4 d 4 d 4 d 4		19a. Informant's Name/Relationshi Shirley Powell		i				per, City or Town, State, Z	
Dallinore, IN permit. Pages 1 and 2 Department of Health Important: If Itam 271 any injury or other tre		20a. Method of Disposition 1 □ Bullial 2XX remation	3 □Removal from Star	20b. Place of Disposers	position (Name of ematory or other place	٨	ug. Date8,	nville, FL 20c. Location - City or 7	
Dallillor Dermit. Pages Department of mportant: If It nny injury or o	once.	4 ☐ Donation 5 ☐ Other Social Service Li	**	Metro Cr		s of Facility	2004 Funeral Ho	Catonsville,	MD
0 80E	a	143	M	4	21 Crain H	lwy. S	.E. Glen B	urnie, MD 21	
Physicia	an	23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final	omplications that caus	ed the death. Do not e		g, such as o		arrest,	Approximate Interval Between Onset and Death
/Medic	al	disease or condition resulting in death)	a. Due td (o) a	as a consequence of):	11/20	CNO	Λ		
	er er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (o	s a consequence of):	\				
axecuted a and al-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	as a consequence of):					
of ou,	dicai	,	d						
The COLUS, F.O. DOX 00 / 00, The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown		2 Fetal death 3 at time of death 5	☐Ectopic pregnancy			23d. Date of deliv	ery Day Year
us, F., uires that the signed by d be detact	by Phy	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause give	en in Part I.	23e. Did	tobacco use contribute to	he cause of death?
w requires to been signed should be	ted b						10	Yes 2 □ No 3 □ Pro	bably 4 nknown
VICAL DEC vician: The law certificate has b	Completed						1 ☐ Yes	psy prior to coordinate of the	opsy findings available impletion of cause of
OI VITAL Physician: this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2XXNo	Hospital:	itient 2 ER/Outpati	ent 3 DOA Oth	-	of Death (Check only sing Home XX Resi	one) idence 6 □Other (Speci	fv)
ding Phy After this	ion:	27. Manner of Death 1X Natural 5 ☐ Pending		njury 28b. Time Day Year) Injury	Worl		28d. Describe	how injury occurred	,,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of I	njury - At home, farm, s etc. (Specify)		103 2 2 11	28f. Location (Street and Number or Rur wn, State)	al Route Number,
a Hospite 24 hours a Funera etely fille	edical C	29a. Certifier Certifying (Check only one)	Physician: To the bes xaminer: On the basis and manner	or examination and/or	investigation, in my of	pinion, death	h occurred at the time,	cause(s) and manner as s date and place, and due t	stated. o the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Month,	Day, Year)
^		30. Name and address of person w	no completed cause of	f death (Item 23a) (Tun	D Print)	2230	162	August 16, 2	21061
7		Jude Money	es mo	7845	Doku	bood	Road (Slen Burnie	AM
	State istrar	31. Date filed (Month, Day, Year) AUG 1 7 2004	32. Regis	strar's Signature	Sporks		for Pood (

			For State Registrar	State of Maryland	d / Departm			Mental Hy	giene	25754
,	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MARY RAND	OLPH				2. Date of De Month	Day Year	123 C Po // 14
<i>></i>	Examin	er	4a. Facility Name (If not institution, give st	reet and number)	4b. C		ocation of Death		4c. County of De	N/A
	Funeral Director		40 01-0101	M 20 F 7. Age (In yrs. la	(Yrs. If Ur		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 9. B	inthplace (State or Foreign Country)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County A		Town or Location	Ore		<u> </u>		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the a or 28a be not	Director	10e. Street and Number	epet	10f.	Zip Code	1223		10g. Citizen of What C	. '
20	hours after death with the Maryland turet, or freme 23a or 28e-f ehow al Examinat must be natilised al	by Funeral		2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give	1		panic Origin? (S Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - Arr Black, Wh	nerican Indian,
31215-0U36	filed within 72 hours after death with the Marylan Hygiene. ther then "naturelt, or lieme 23a or 28a-1 ehow int, the Madical Examinar must be notified at	Completed to	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: ation completed) College (1-4or 5+)	life. DO NO	f work done du T use retired)	ion ring most of wor		16b. Kind of Busines	
n n	be filed tat Hyg d othe event,	To Be Co	8th grade 17. Father's Name (First, Middle, Last) JULIUS SMI	TH	NURSI		8. Mother's Nan	ne (First, Middle,	Maiden Sumame)	,
-	and 2 should eaith and Men n 27 is marke		19a. Informant's Name/Relationship (Typ	DOLPH				_	er, City or Town, State,	
nore,	of H of H fiter		20a. Method of Disposition 1	emoval from State	ace of Disposition (metery, crematory)	(Name of or other place)		Date 20 · 04	BALTO. A	
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service License	1		e and Address	of Facility	e FUNE	RAL SERV	ICES 21229 BALTO MD
			23a. Part1. Extenthe disease, or complice shock, or heart failure. List only on		. Do not enter the r	mode of dying,	such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		Cardi	osvasc	ular D	Mase	
	ir jūr	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	End Stag	ence of):	at C	usea	e		
,09/	ate be executed nysicien and he burial-transit	cal Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequent	ence of):	aug				
.O. Box 68	ath certifica attending pt for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3 Ectopi	ic pregnancy (specify)			23d. Date of d Month	elivery Day Year
Q _	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resul	lting in the underlyi	ng cause given	in Part I.		obacco use contribute	to the cause of death?
I Records,		Completed						24a. Was autor perfo		
Vital	Physician: Th this certificate al director, pag	o Be (25. Was case relerred to medical examiner?	ospital: 205	ER/Outpatient 3□	DOA Other		th (Check only o	one) dence 6 Other (Sp	
Division of	Sing After funer	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury a Work?	at		how injury occurred	өспу)
Divis	al or Attendi safter death if Director: A id in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		ctory, office		28f. Location (: City or To	Street and Number or I wn, State)	Rural Route Number,
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death occur ion and/or investiga	red at the time tion, in my opin	, date and place nion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0 00	D	29c. License	number	_	29d. Date signed (Mor	nth, Day, Year)
,	2		30, Name and address of person who con		23a) (Type, Print)	St F	3 altir	v Ma	MD212	e/
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 2004	32. Registrar's Signate				0-0	USI	-/

			4 101	partment of Health and N	Mental Hyg	jiene	
_			Registrar	ertificate of Death	2 Date of Dea	leg. No	25755-
	Physicia	an	Decedent's Name (First, Middle, Last)		Month	Day Year	3. Time of Death
	/Medic		Anna Wailes Raith 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		14, 2004 4c. County of Death	5:15 P [™]
	Examin	er	Oak Crest Village	Perry Hall			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Baltimore 9. Birth	place (State or Foreign ntry)
	Director		212-01-0063 1 M 2 T 88 Yrs.	Months Days Hours Min.	Sept. 27	7,1915 Mary	land
	pu ,		Usual Residence of Decedent				
	anyla show	5	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	Maryland Baltimcre Perry H	10f. Zip Code		100 Citimes of Mark Co.	^
	with e or	i	8820 Walther Blvd. Apt.3622	21234	'	10g. Citizen of What Cou	ntry ?
	filed within 72 hours after death with the Maryland Hygiene. uther then "neturel", or Items 23e or 28e-1 show snt. The Medical Exam for must be notified at	Funeral			pecify Yes or No-	USA 14. Race - Ameri	can Indian,
ဟ	or Iter	F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	etc.
03	rel', c	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	nite
21215-0036	72 h	Completed	(Specify only highest grade completed) (Gir	cedent's Usual Occupation ve kind of work done during most of work	king	16b. Kind of Business/In	dustry
121	within iene.	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		T -	
	e filed v Il Hygie other t		12 2 Admi	nistrative Assista		Insurance C	ompany
and	d be i	o Be	John Shipley Wailes	Hele			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other then "neturel", or items 23e or 28e-f show or other treumetic event, the Medical Exam her must be notified.	Ç		illing Address (Street and Number or Rur			Code)
, /, 🗟	and 2 sealth ar n 27 is ser trou			Taplow Road Baltim			,
ie ż	s 1 a of Hea item othe		20a. Method of Disposition 20b. Place of Dis			20c. Location - City or To	own, State
15 pm.	Pages nent of h ant: If ite		N Burial 2 Uremation 3 Hemoval from State	Valley Cem. 8/19	/04	Timonium,Ma	rvland
5 alti	permit. Page Department of Importent: If any injury or once.		21. Signatury of Fune by se vice Lice see	22. Name and Address of Facility		1050 Yo	
. · · · · · · · · · · · · · · · · · · ·	80 E E 8		la diff	Ruck Towson Funera	1 Home,I		
40			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Acute Le	eukemia			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
_	_xumino.	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
7	ted nsit	nin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (pissass or ir jury that initiated events c.				
10	be executed sician and burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):				
1/4/ 876	cate be executed physician and the burial-transit	dicai	d				
000	tifical ng phy as th	ledi					
XO	leath certifi attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	*
→ G.	at the dea by the at tached fo	Physician/Me	1 Yes 2 No	Other (specify)		Month	Day Year
9.9 P.0	that the	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underhine eaves even in Dest I	220 Did to	bacco use contribute to t	he eques of death?
ds,	se un eq	by	Parch. Other signmean conditions communing to death bachories uping in the	underlying cause given in Fart i.		es 2⊠No 3∏Prot	
Too	w require been si should	ompieted			_		
Rec	has ge 2	ld m			24a. Was a autops	sy prior to co	ppsy findings available impletion of cause of
1 Silver	10 17	e Co	25. Was case referred to medical	00 81(-0		2 No 1 Yes	2 40
± ₹	Physicien: this certific	o B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Deat		ence 6 □Other (Specil	6-1
0	ding Phy h. After this funeral c	-	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ow injury occurred	<i>y</i>)
0.5	Attending or death. sctor: After by the fune	atio	1 Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	y Work? M 1 ☐ Yes 2 ☐ No			
$\mathcal{B}_{\text{division}}$	or Attendiater death. Director: A	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	street, factory, office	28f. Location (Si City or Town	treet and Number or Rura	al Route Number,
Ō	rs after rel Directed Directed	Cer					
	Hospl 24 hou Funer tely fill	edical	29a. Certifier (Check only one) 1 ★ Certifying Physicien: To the best of my knowledge, de (Check only one) 2 ★ Medical Exeminer: On the basis of examination and/or and manner stated				
_	To the Hospital or A within 24 hours after To the Funerel Direc completely filled in by	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Month,	Day, Year)
			an morrows	D286 4 P		August 1	5 360 4
_ `			30. Name and address of person who completed cause of death (Item 23a) (Typ	oe, Print) Anna Mo	nic s	,-,,	7
	10		8800 walther Boulevage	Sports	m	2123	34
	Sta Regist		31. Date filed AVOIG Pay, Year 2004 35 Registrar's Signature 9	sports			

Physician Particular Particu	1-	For Stata Registrar	State of Marylar		irtment of H			iene	1. 25750
## City Town of Location of Seath		. Decedent's Name (First, Middle, Last)	n				2. Date of Death Month	h Day Ye	
## State Sta	ledical				4h City Town or	Location of Deat			
Fundamental Directors Compared to the Comp	aminer 44.						"	,	
December Section of December 100. City, Town of Location 1	-I al	. Social Security Number 6. Sex	7. Age (In yrs.				8. Date of Birth (Month, Day, Sept. 2	year) 946 .	Birthplace (State or Foreign Country) Jamaica
17. Father's Name (First, Middle, Matchen Sumanne) 17. Father's Name (First, Middle, Matchen Sumanne) 17. Father's Name (First, Middle, Matchen Sumanne) 18. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Albert 19. Mailing Address (Sheet and Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or Plural Flour's Number, City or Town, State, Zir of Number or P			10c. C	ity, Town or Lo	cation				10d. Inside City Limits
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Type Frank (Gothe Laty) 17. Father's Name (First, Middle), Matchen Sumane) Attition Gilbert Johnson Gilbert Johnson Matchen Sumane) Attition Gilbert Johnson Matchen Sumane) Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 2120 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 2120 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 2120 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 2120 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 6110 Twillight Court, Battimore, Mp 21236 Min. Augustus Recec (husband) 61	by Fune	1 Never Married 2 🕱 Married	Armed Forces? 1 ☐ Yes 2 🂢 No If Yes, Give				to Rican, etc.)	Black, \	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	State ³	Greg ay	OKrywka i	no	SIS FAI	rmout A	Venue #	300/7	Ousan MDZ123

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	Funeral Director		Prince George's Ho 5. Social Security Number 6. S n/a		birthday) Yrs.	Cheverly If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	Pr	rince Ge	orge 's
	yland low		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside City Limits
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	th with the 23a or 2 ust be no		10e. Street and Number n/a			10f. Zip Code 9069	98			izen of What Cou Israel	intry?
920	hours after death with the Maryland turel', or Items 23a or 28a-f show at Examitter and be matified at	by Funerai	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	D-	14. Race - Amer Black, White Specify: Wh	
Maryland 21215-0036	within 72 ene. then "nat	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation (de completed) College (1-4or 5+)	(Give life. L		ation during most of work l)	ing		ind of Business/Ir	ndustry
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Mary	12 sh h and 7 Is m treum	•	19a. Informant's Name/Relationship (and Number or Rura			or Town, State, Zi	o Code)
Baltimore,	Pages 1 and 3 nent of Health ont: If item 27 ury or other tru		20a. Method of Disposition 1	20b. Place	of Dispos	sition (Name of	۱ (م	Date	20c. Lo	ocation - City or T	own, State en, Israel
Balti	permit. Pag Dep. rtment Importent: I any injury o		21. Signature of Full rail Service Licer	Ball	22	Name and Address	ss of Facility To1	rchinsk	у Не	brew Fun	eral Home
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f Vit	S 5	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☑ ER/0	Outpatient	t 3□ DOA Othe	26. Place of Death			3 □Other (Specif	iv)
Division of	ding h. After fune	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	8-15-04 1	Time of Injury	PM 28c. Injury Work 1 \(\)	at 2	28d. Describe			
Divi	tel or Attents after deat al Director:	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre			28f. Location (S City or Tov	Street and Va State	Number or Rura	Al Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	lge, death and/or inv	occurred at the tim estigation, in my op	e, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To the within 2 To the complet	×	29b. Signatore and title of certifier	· Don		29c. License				e signed (Month,	
, h			30. Mayne and address of person who	completed cause of death (Item 23a	L Augar) (Type, F	OC OC				st 16, 2	
7			31. Date filed (Month, Day, Year)	32. Registrar's Signature	11:	l Penn St	reet, Bal	timore	, Mai	ryland 2	1201
	Sta Registr			004 Server	19	Spark	2				

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #5 PER FH C834 8025 # Office to The Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month Year GRANT RINES AUGUST 10:10 A.M 2004 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL MARINER HEALTH OF FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5**218¹³14¹¹9**519 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Vrs 80 Director 46 Dec.28,1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 TYes 2 No Maryland Director Baltimore Essex 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21221 238 34 Pelczar Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed withIn 72 hours after 1 ⊠Yes 2 □ No If Yes, Give WW Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ Specify: White 3 XWidowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician Steel Mill 12 other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Samuel Rines Beulah Loueenslager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 953 Walters Mill Road Forest Hill, Maryland 21050 Grant A. Rines Jr. (Son) If item 27 i 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State 20 permit. Page Department of Importent: If any injury or once. Holly Hill Mem. Gardens 8/19/2004 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature @ Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1. Enter the disease, or complications that caused the death. ck, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue Essex, Md. 21221 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physiclan** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending for use as use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Ö 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 □ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 1 Yes of Vital 25. Was case referred to examiner? Attending Physician: director. Be blace of Death (Check only one) Hospital: Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this a 27. Mann Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident filled in by the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide ō within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MANUEL LAZATIN 8 LAW STREET ABERDEEN, MD. 21001

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

7 2004

AUG 1

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please T	ype or Print in			•		gible.	
		For State	State of Marylar		nt of Health a te of Death	and Mental H	20	101	20200
		Registrar 1. Decedent's Name (First, Middle, Last)		Certifical	e or beaut	2. Date of D	Reg. No. (J (1 L5	3. Time of Death
Physici /Medic		Paul Junior Stin	nchcomb			Aual	LIT Day	Year LeVCH	5-85 PM
Examin		4a. Facility Name (If not institution, give	street and number)		Town, or Location of	of Death	4c. Cou	inty of Death	
		5. Social Security Number 6. Sec	Hospital		r 1 Year If Under	24 Hrs. 8. Date of B	HO	ne M	rundel
Funeral Director			M 2□F 57	Yrs. Months		Min. (Month, I	irth Day, Year) 12, 194	6 Ma	lace (State of Foreign try) ryland
pu »		Usual Residence of Decedent 10a. State 10b. County	110- 0	ity, Town or Location					
Aaryla f shor	ō			•				10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
the h	rect	MD Anne A	Arundel	Glen Bu	Code		10g. Citizen	of What Coun	try?
th with	Funeral Director	17 Queen Ann Road			210	60.	Un	ited S	tates
er dea	uner		12. Was Decedent Ever in L Armed Forces?	J.S. 13. Was Dece If Yes, spe	dent of Hispanic Ori ecify Cuban, Mexican	gin? (Specify Yes or N , Puerto Rican, etc.)	lo- 14. F	Race - America Black, White, 6	
be filed within 72 hours after death with the Maryland the Hygiene. d other than "neturel", or items 23a or 28a-f show event, the Modical Evaluinar must be routified at	by Fi	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	1	1 ☐ Yes	2Ñ No Specify:		Spe	cify:	White
2 hou		15. Decedent's Edu	cation	16a. Decedent's Usu	al Occupation	A - 6 - 4 - 1	16b. Kind of	f Business/Ind	lustry
iffin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		ork done during most ise retired)	t of working			
iled w Hygier her th		8 17. Father's Name (First, Middle, Last)		Welder		n's Name (First, Middl			Company
d be f ental i	To Be	Ernest Clifton St	inchcomb		TO. MOUTE	Katherin			nuorlino
should and Men s marke umatic	-	19a. Informant's Name/Relationship (Ty		19b. Mailing Addres	s (Street and Numbe	or or Rural Route Num			
permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netur any injury or other treumatic event, the Medical once.		Barbara A. Stincho				Glen Burn	ie, MD	21060	
Pages 1 nent of Ho nnt: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State 20b.	Place of Disposition (Na cemetery, crematory or en Haven Me	me of other place)	Date	20c. Locatio	on - City or To	wn, State
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The law ate has l	mpl						s an 24t opsy ormed?	 b. Were autop prior to com death? 	sy findings available apletion of cause of
	e Co	25. Was case referred to medical			26 Place	1 ☐ Yes of Death (Check only	2 No	1 ☐ Yes 2	2 □ No
hysicien: The his certificate I director, pag	OB	examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3 D	0.1	rsing Home 5 Res		Other (Specify))
ng Pl	on: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		how injury occ		
Attending Physicien: or death. ector: After this certifica by the funeral director.	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OG - Disco of lainer. At h	M	1 Yes 2 1		/Ca	t D (Davida Marahar
after after Direct In by	ertif	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		у, опісе	City or To	own, State)	m <i>ber or Hurai</i>	Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Cartifying Phys	sician: To the best of my kno	owledge, death occurred	at the time, date and	d place, and due to the	cause(s) and	manner as sta	uted.
the Ho iin 24 the Fu	ledical	one	ner: On the basis of examina and manner stated.			h occurred at the time			
To t To t	Σ	29b. Signature and title of certifier	N.	29	c. License number	6	29d. Date sign		
		20000	·	1155	04514	4	rugus	51 14	2004
		30. Name and address of person who co	BOY 1-10500	m 23a) (Type Print)	re 9 Ca	en Burn	ie m	S (061
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa)				
Registr	ar	AUG 1 7 2004	Peneron	4 1	2.11				

			1 - For State Registrar		Marylar	•			lealth a Death	and M		Reg. No.	004	25	761
П	Physici	an	Decedent's Name (First, Middle, L.	ast)							2. Date of Dea Month	ith Day	Yea		of Death
	/Medic		Miriam		11y	Sh	aeffe	er			August	14,	2004	6:00	a ^M
	Examir		4a. Facility Name (If not institution, gi	ve street and numi	ber)		4b. City		Location o	of Death		4c. C	county of De		
			5 Waugh Avenue				Milad	Glyn er 1 Year		0.4 Usa			Balti		
	Funeral Director		5. Social Security Number 6. 219-22-8317 Usual Residence of Decedent	Sex 7 1 M 2 M F	78	last birthday) Yrs.	Months		If Under : Hours	Min,	8. Date of Birth (Month, Day Dec. 10	, Year) , 19	25 9.8	irthplace (State Country) Marylar	e or Foreign nd
	land ow		10a. State 10b. County		10c. C	ty, Town or Lo	ocation							10d. Inside	City Limits
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ဖွ	or Its	豆	1 ☐ Never Married 2 🖾 Married	1 ☐ Yes 2	No No	1	Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:						Black, Wh Specify:		
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7	be filed within 72 hours after death with the Marylan sta thysiene. st other then "natural", or itams 23s or 28s-f show avent. Its Medical Examana must be notified at	ပိ	12 17. Father's Name (First, Middle, Las	t)		OII	TCC .	Imp±0		r's Name	e (First, Middle,			- DPIC	
an	Mental Mental Arked o	To Be	Leonard		11y				Eva		Vau				
Maryland 21215-0036	should be ind Mental marked umatic av	Ĕ	19a. Informant's Name/Relationship			19b. Maili	ng Addres	ss (Street a	and Numbe	r or Rura	al Route Numbe		Town, State,	Zip Code)	
Σ	27 is		James W. Shaeffer	Husban	d						n, Mary		2107		
Baltimore,	s 1 au if Hea item othe		20a. Method of Disposition	_		Place of Dispo	osition (Na	ame of	a)	C	Date	20c. Loca	ation - City o	or Town, State	
Ē	Page lent o nt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Cremation 3 ☐ Other (Special Control of C		late I	. John	-	-		8/	17/04	Westi	minste	er, Mar	yland
alti	permit. Pages: Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lice	ensee /	'	2:	2. Name a	and Addres	s of Facilit	у 1	1824 Re	iste	rstowr	Road	
m	Depa Impo any in		Kamb &	lin		E	LINE	FUNE	RAL H	OME	Reister	stow	n, Mar	yland	21136
	/Medical Examiner	Iner	23a. Flart1. Enter the disease, or conshock, or heart failure. List only mediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or Injury)	a. Due to (o	ch line.	quence of):		_	_			631 ,		Approxim Interval B Onset and	etween
,0928	icate be executed physicien and s the burial-transit	edical Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (o	cDue to (or as a consequence of): d										
.O. Box 6	that the death certificate ed by the attending phys detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 X No 9 □ Unknown		th 2 ☐ Feta nt at time of o	aldeath 3		oregnancy specify)				23	d. Date of de Month	elivery Day	Year
S, D	es thai igned t	by P	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use	contribute	to the cause of	f death?
ord	w requires been sign should be										1 🗆 Y	es 2 🔀	No 3∏F	Probably 4	∃Unknown
Records,	n: The law n icate has be r, page 2 sh	Completed									24a. Was a autops perfor	sy	prior to death?	utopsy finding completion of s 2 \(\sum \text{No} \)	s available cause of
Vital	sicien: certific rector,	Be (25. Was case referred to medical examiner?								(Check only or				
of V	S D	ို	1 ☐ Yes 2 XNo	Hospital: 1 🗆 In	patient 2	ER/Outpatier	nt 3 🗆 🗅			rsing Ho	me 5 Resid	ence 6 [Other (Sp	ecify)	
n o										28d. Describe h	ow injury o	occurred			
sio		catl	2 Accident investigation M 1 Yes 2 No												
Division	or Atten after deat Director: in by the	Ħ	4 Homicide determine	286. Place 0	of Injury - At h g, etc. <i>(Speci</i>		reet, tacto	ry, office			28f. Location (Si City or Town		Number or F	Rural Houte Nu	ımber,
ш	Hospitel 4 hours Funeral	edical Ce	29a. Certifier (Check only one) 124 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and cand manner stated.						nd manner a lace, and du	is stated.)(s)				
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and maille	, stateu.		25	9c. License	number	-	2	9d. Date	signed (Mor	ith, Day, Year)	
)	F 3 F 8		M.C. Cla	will war	•			DS	493	7		011	11.	17	
	./		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type.	Print)					_		(
	84			owse v		6701	N-C	harle	es St	Rm	5705	Balt	more	e mo z	1204
	Sta Registi		31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature &	So	alex)	-	5705				

			1 - State Registrar	State of Maryla		tment of H			0001	0.57.79.4.5
I	Physici		Decedent's Name (First, Middle, Last)	linale				2. Date of Deat Month	h Day Yee	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s FOX CMSE M 5. Social Security Number 6. Sec.	ursing H	ome	4b. City, Town, or 2015 If Under 1 Year Months Days	East If Under 24 Hr. Hours Mir	WESTI-G	4c. County of De	ath COUNTY Attriblace (State or Fordign Journity) KNOWN
	yiend now		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loca	tion			5/ 41	10d. Inside City Limits
	the Mer 28a-f sh	Director	MD Montgome	ery	Silver	Spring 10f. Zip Code			2- 65	1 ☐ Yes 2√∑ No
	th with	ai D	2015 East West Hg	gwy		·	20910		og. Citizen of W hat (USA	ountry?
036	within 72 hours after death with the Merylend ene. Then "neturel", or iteme 28a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	unk _	s Decedent of Hi es, specify Cubar Yes 2 No	spanic Origin? (in, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify:	nerican Indian, ite, etc. White
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylen Dapariment of Heelih and Meniel Hygiene. Importment of Heelih and Meniel Hygiene. Instruction the Meniel is marked other than "naturel, or iteme 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12) unk	cation e completed) College (1-4or 5+)	(Give kir	nt's Usual Occupa ad of work done d NOT use retired;	luning most of we	orking unk	6b. Kind of Busines	s/Industry unk
Maryland 2	uid be filed Mentei Hyg Irked othe Itlc event,	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	me (First, Middle, N	faiden Sumame)	unk
Mary	12 sho h end ? 7 is me treume		19a. Informant's Name/Relationship (Ty)						City or Town, State,	Zip Code)
Baltimore, I	Peges 1 end nent of Heelt int: if Item 2 iry or other		Fox Chase Nursing 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 ☑ Office (Specify)	20b.	2015 Ea Place of Dispositi cemetery, cremai	on mame or		lver Spri	no MD 2 Oc. Location - City o	0910 r Town, State
Balti	permit. Dapertn Importe any Inju		21. Signature of Funeral Service License	ade, Divecto	Bal	ame and Address ite Anato timore,	s of Facility Boar MD 212	d 655 W.	Baltimore	Street
	Cate be executed Physician end Examiner the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishoots, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection) Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	Quence of): RAL quence of): C P P P P P P P P P P P P	_	URY SY	c or respiratory arre		Approximate Interval Between Onset and Death
Box 6	death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of a 9 ☐ Unknown	aldeath 3□Ec	topic pregnancy ther (specify)			23d. Date of de Month	livery Day Year
rds, P	w requires that been signed b should be dete	5	Part II. Other significant conditions con	tributing to death but not re	sulting in the unde	rlying cause give	n in Part I.			o the cause of death?
al Reco	Physicien: The lew requires that the this certificete has been signed by the director, page 2 should be deteched.	Completed						24a. Was an autopsy perform	ed // death?	utopsy findings available completion of cause of
<u> </u>	ysicien s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:] ER/Outpatient			ath (Check only one) ice 6 ∏Other (Spe	
0	ing Ph After th	Di: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how	vinjury occurred	city)
Divislo	To the Hospital or Attending Ph Within 24 hours effar deeth. To the Funerel Director: After th completely filled in by the funerel	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street,		es 2 No	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	edical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knoer: On the basis of examina and manner stated.	owledge, death ocation and/or invest	curred at the time	e, date and place inion, death occu	, and due to the cau irred at the time, dat	ise(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the Company	Me	29b. Signature and title of certifier	PHYSICIP	int	29c. License	number) 6109		1. Date signed (Mont	**
			30. Name and address of person who cor USHA GOLLA 31. Date filed (Month Pay Year)	npleted cause of death (Item	n 23a) (Type, Prir	11) 5 SHA	DYED	OVER	DAD ROCI	CVILLE MODDE
	Sta Registra	16	31. Date filed (Month, Day, Year)	JZ. Registral's Signi	ature A	land	/			, \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\

			For State Ragistrar	State of Ma	yland / Dep	partment of F	lealth and M	lental Hygi	ene g. N2. () () ()	25763
			Decedent's Name (First, Middle, Last)	··			-	2. Date of Death		3. Time of Death
	Physicia	an	, , , , , , , , , , , , , , , , , , , ,	James Ga	rrett	Sacra, Jr	_	Month	Day Year 13, 2004	7:00 A M
	/Medic		4a. Fecility Name (If not institution, give si				r Location of Death	August	4c. County of Death	
	Examin	er	9511 Shirewood Co				Marsh		Baltimo	
			5. Social Security Number 6. Sex		(In yrs. last birthday		If Under 24 Hrs.	9 Date of Righ		
	Funeral Director		219-10-9214	M 2□F 86	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, March 21	Year) Cou L,1918 Vii	place (State or Foreign intry) ginia
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	sho	'n	Marra 1 3		•		* **			1 ☐ Yes 21X No
	18a-6	Director		imore		10/ 7: 0-1-	Wr	nite Mars		
	vith t		10e. Street and Number			10f. Zip Code	21227		g. Citizen of What Cou	
	ath v	ra	9511 Shirewood Cou				21237		Inited Stat	
	er de	Funeral		Was Decedent Ev Armed Forces?	er in U.S. 13	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Spa an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	afte of land	by Fi	1 Never Married XXMarried	1XXYes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Specify:	r. 7. 1. 1.
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show diest Examinat must be motified at		3 Widowed 4 Divorced		WWII					White
7	72 inat	ete	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business/li	ndustry
2	vithin ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) [Steel In	d. atre
2	lygie her t		8 Years			rane Opera	18. Mother's Name	- (First Mindels NA		dustry
in c	be fi	Be	17. Father's Name (First, Middle, Last)	Cro					ly Berryman	
yla	ould Men Marke	2	James Garrett Sa							
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ahow any injury or other traumatic event, the Madical Examiner must be notified at once.	g B	19a. Informant's Name/Relationship (Typ						City or Town, State, Zi Sh, Maryla	
2	and ealth n 27 ner tr		Mrs. Virginia E. S	acia / Wi						
Baltimore,	of Hi of Hi if iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	emoval from State	20b. Place of Disp cemetery, cr	position (Name of ematory or other place			0c. Location - City or T	own, State
Ĕ	Pag ment ant: I		'4 ☐ Donation 5 ☐ Other (Specify)	,o.u.	Oak Lawr	n Cemetery	8/16/20	004	Baltimore	, Maryland
alt	permit. Departr Importa any inju		21. Signature of Funeral Service License	·/ /	0	22. Name and Addre	ss of Facility Funeral	Home of	Dundalk, I	nc.
m	Pe E E		12. (. (aus		7922 Wise				1222
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused to	he death. Do not e					Approximate Interval Between
	Pnysician		Immediate Cause (Final	α		ALCINOMA	0			Onset and Death
	/Medical		disease or condition resulting in death)		consequence of):	HCENIOCITI	τ			
	Examiner				, , , , , , , , , , , , , , , , , , , ,					
	S. Const	e	Sequentially list conditions, if any, leading to immediate cause. Enter the striping		consequence of):					
1	uted d ansit	min	Cause (Disease or injury that initiated events							
,	death certificate be executed e attending physician and id for use as the burial-transit	Examiner	resulting in death) Last	Due to (or as a	consequence of):					
1760,	sicia bur	call	4							
89	ficate phy s the									
×	feath certificat attending phy I for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome o					23d. Date of deliv	erv
Вох	atter for u	clar	in the past 12 menths?	1☐Live birth 2 4☐Pregnant at ti		☐ Ectopic pregnancy ☐ Other (specify)	′		Month	Day Year
O.	that the death ed by the atter detached for	ıysi	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9□ Unknown						
Δ.	The law requires that the ste has been signed by thoage 2 should be detache		Part II. Other significant conditions con-	tributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	he cause of death?
ds,	uires sign ld be	d by	CORONARY ARTE	Try Dis	EASE			1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
Ö	w require been sig should b	ete	PARKINSON'S	Dic ive				24a. Was an	24h Wara aut	opsy findings available
of Vital Record	has has	ompleted	I ARUNSON 3	DIREKSE			·	autopsy	prior to co	ompletion of cause of
=		Co	_						No 1 ☐ Yes	2 □ No
Vit	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death	2		
of.	this al di	5	1 185 294110	1 Linpatien		ent 3 DOA	4 Nursing no	-	ce 6 Other (Speci	fy)
		o	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Wor	k?	28d. Describe hov	vinjury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 No	206 1		10-1-11
Division	after death after death Director: d in by the t	ertification;	4 Homicide determined	building, etc.	y - At home, farm, s <i>(Specify)</i>	street, factory, office		City or Town,	et and Number or Rur State)	ar Houte Number,
	urs a gral E	0					N N			
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E	ledical	29a. Certifier 1 Cartifying Phys (Check only one) 1 Madical Examin	ar: On the basis of and manner state	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as a se and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manifer state		29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
.	F ≱ F 8		Num State			D	35410	A	west 16.2	400
Z.	14		30. Name and address of person who con	mpleted sauss of the	ath (Itom COc) (T	Print)			8	- I
	110		1 10 00000	mpleted cause of de	18 RIT	GE RA	BALDMORE	E, MO	d. Date signed (Month.) ufust 16, 2 21237	
	Sta	10	31 Date filed (Month, Day, Year)	32 Registrar	's Signature	BALLS	10	/	*	
	Sta Registr		AUG 1 7 2004	Strallist.	1 20 6%					

			For State Registrar	State of M	aryland / Depa	artment of H				ene g. NG. [] [and the same of th	25761.
			Decedent's Name (First, Middle,	Last)					2. Date of Death		1 11	3. Time of Death
	Physici /Medio		Thomas	R. Skaggs	, Sr.			P	ugust 1	4, 200	4 Year	8:20 a M
	Examir		4a. Facility Name (If not institution,	give street and number))	4b. City, Town, or	Location of	of Death		4c. County	of Death	
			424 Darby Lane			Bel /		O4 Uro		На	rford	
	Funeral Director			5. Sex 7. Ag 1 ☐ M 2 ☐ F	ge (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, March 6,	Year)	Cour	nlace (State or Foreign
			215-28-2359 Usual Residence of Decedent	Λ	71 ''s.				rarcii o, .	1933	Maryl	anu
	nyland how		10a. State 10b. County		10c. City, Town or Lo						1	0d. Inside City Limits
	the Marylar 28e-f show	Director		ford	Bel Air	•						1 ☐ Yes 2X☐ No
	or 2	Dire	10e. Street and Number			10f. Zip Code			10	g. Citizen of \	What Cour	ntry?
	s 23e	rai	424 Darby Lane	10.111.0	F 110	21015				USA		
	ter de Item	Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent	?	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori in, Mexicar	igin? (Spec n, Puerto R	cify Yes or No- lican, etc.)		e - Americ ck, White,	
036	urs af	by	3 ☐ Widowed 4 ☐ Divorced	d 1 X Yes 2 ☐ If Yes, Give Year or Dates:	no Noi ea	1 ☐ Yes 2 ☐ No	Specify:			Specify	v: Whi	te
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "naturel", or Items 23e or 28e-1 show event, the Madical Examination usite multiples at	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	dent's Usual Occupa	ation		_ 1	6b. Kind of B	usiness/Inc	dustry
2	ithin ;	nple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	kind of work done o DO NOT use retired	i)	t Of WORKIN	9			
121	led w lygier her th		12	n/a	Elec	ctrician				.oca1 #2		
Maryland	should be filed withir nd Mental Hygiene. i marked other than Imatic event, ITEM.	Be	17. Father's Name (First, Middle, La						(First, Middle, M		•	
Ž	s 1 and 2 should if Health and Men item 27 is marke other traumatic	2	Paul S 19a. Informant's Name/Relationshi	Kaggs Crupa Print	19h Maili	ng Address (Street a		llian	Pauta Number	<u>Mille</u>		Codel
S	nd 2 sho		Helen Matthews-comp			Darby Lane,				Juy or Town,	этагө, гір	Code/
<u> 5</u>	s 1 and 2 i Health item 27 i		20a. Method of Disposition	arron	20b. Place of Dispo	sition (Name of				Oc. Location -	City or To	wn, State
9	Pages nent of I int: If it		1 X Burial 2 Cremation 3 1 Donation 5 Other (Spe			matory or other place Faith Cemet		R/18/0	4	Baltim	ora M	n
Baltimore,	permit. Pages 1 a Department of Hes Importent: If item any injury or othe once.		21. Signature of Funeral Service Li			2. Name and Addres			onard J. F			
8	825 8		Mulk			305 Harford	d Rd.,				O. 1 OII	ci ai noic
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause one cause on each I	d the death. Do not ent	er the mode of dying	g, such as	cardiac or	respiratory arres	t,		Approximate Interval Between
	Pnysician	i o	Immediate Cause (Final disease or condition	Meta	static E	sophagea	l	Lar	rces			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	, 1						1
		-	Sequentially list conditions,	b. Due to for as	a consagrantia ofir							
,00	uted 1 Insit	Examine	cause. Enter Underlying Cause (Disease or injury		,							
Ć	execting and items in all-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):							
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai		d		- 7						
9	artifice ing pt a as ti	Med	IF FEMALE:					-		-1-		
Вох	eath certific attending p I for use as	lan/i	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy				23d. Dat	e of delive	ry Day Year
0.	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant a 9☐ Unknown	t time of death 5	Other (specify)				1475		oay roar
Δ.	that til ed by detac	/ Ph	Part II. Other significant condition	s contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.		23e. Did toba	cco use conti	ribute to th	e cause of death?
Vital Records,	The law requires that the to be signed by the bas been signed by the bage 2 should be detache	d by			_				1 ☐ Yes	2□No	3 Proba	abiy 4 Unknown
S	w requires been so should	Completed							24a. Was an	24b. V	Nere autor	osy findings available
Be	The fav	omp	,						autopsy performe	102	prior to con death?	pletion of cause of
İta		0	25. Was case referred to medical				26. Place	of Death (1 Yes 2 (Check only one)	No 1	□Yes	21
of V	Physician: this certific ral director,	To B	examiner? 1 🗆 Yes 2	Hospital: 1 🗆 Inpatie	ent 2 ER/Outpatien	it 3□ DOA Othe	9r: 4 □ Nu	rsing Hom	e 5 Residen	e 6 □Oth	er (Specify)
	fe fe		27. Manner of Death 1	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	28c. Injury Work	at	28	3d. Describe how	injury occurr	ed	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investiga 3 Suicide 6 Could no	t be			Yes 2 □ ì					
Division	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide determin	ad 286. Place of In	jury - At home, farm, str tc. <i>(Specify</i>)	eet, factory, office		28	3f. Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
_	Hospital 24 hours 8 Funeral I		29a. Certifier Jertifying	Physician: To the best	of my knowledge, death	1 occurred at the tim	ie, date an	d place an	nd due to the care	se(s) and ma	nner as st	ated.
	To the Hospital or a within 24 hours after To the Funeral Direction Completely filled in b	Medical	(Check only 2 Medical Ex	ceminer: On the basis of and manner st	of examination and/or in	vestigation, in my op	oinion, deat	th occurred	at the time, date	and place, a	and due to	the cause(s)
	To th withir To th comp	ĕ	29b. Signature and the of certifier	00	Cological	29c. License	_		290	. Date signed		
			Kikul	Dones	cere	1000	569	19		08/10	0/04/	
	12		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	4 / 4	-	1		WNS		A 1 D -
	10		31. Date filed (Menth Day, Year)	1UY US	rar's Signature	cite 20		Jest	10	WNS	on,	140,21204
	Sta Registr		31. Date filed (Many) Day, Year)	04		Sports/	,				ŕ	Ĭ
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			For State		State of iv	/laryland / [Certificate			ental Hy	20	Oi.	25765
			Registrar 1. Decedent's Name (Fig. 1)	irst, Middle, Las	st)		Certificate	- OI DE		2. Date of De	Reg. No.	UH	3. Time of Death
	Physici /Medi		Thelma		nerine	Starkey	У			Augu	15+ 14	2004	1 12 STA
	Examir	ner	4a. Facility Name (If not	C -	- 11	1 110	4b. City, T	own, or Loc	cation of Death	-, /	4c. Cou	nty of Deat	th
			5. Social Security Numb		are Ho	SOITA	thday) If Under	Sed Year If	Under 24 Hrs.	0 Data of Di-	1501		10FE
	Funeral Director		215-22-1374		□M 2 7 F	0.0			lours Min.	8. Date of Bir Month, Da Ugust 5	1921	Co	thplace (State or Foreign buntry) u ry land
	pu >		Usual Residence of Dec	b. County		40.0.7						1 1 10	a y rana
	Aarylan f show	ō	MD	n/a		10c. City, Town							10d. Inside City Limits 1 ✓ Yes 2 □ No
	the N	Director	10e. Street and Number			Daiti	10f. Zip (Code			10g. Citizen	of What Ca	
	h with		4404 Raspe	Avenue				21206				USA	outility :
	r dea	Funeral	11. Marital Status	, , conse	12. Was Deceden Armed Forces	t Ever in U.S.			nic Origin? (Spec lexican, Puerto R	ify Yes or No	- 14. F		rican Indian,
36	rs after death with the Maryla I, or Items 23a or 28a-f shov	by Fi	1 ☐ Never Married 3 ☑ Widowed 4 ☐		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	χNο	1 ☐ Yes 2		pecify:				ite
1 ma 21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or tems 23a or 28a-f show the Modical Examiner must be notified at		15.	Decedent's Ed	ucation		Decedent's Usual	Occupation			16b. Kind of		
215	d within 7 giene. ir than "r	Completed	Elementary/Secondar	y (0-12)	de completed) College (1-4or		(Give kind of work life. DO NOT use	done durin retired)	g most of working	g			
e/ma	ס ה	Cor	12 17. Father's Name (Firs	t Middle (and)	n/a		C1erk					ail Sa	les
$\mathcal{I}_{\mathcal{C}}$	ed ala	Be c	_	Henry	Wright			18.	Mother's Name	(First, Middle,			
I la	should and Men is marke aumatic	6	19a. Informant's Name/			19b.	Mailing Address (Street and I		Route Numbe	Sprech		in Code)
-∑	and salth	ľ.	Gary D. Star	kev-son					ue, Baltim			,, olalo, 2	,p 0000)
yr Keγ Baltimore	of He of He If item or oth		20a. Method of Disposit	ion emation 3 □I	Removal from State	cemeter	Disposition (Name v, crematory or oth	of of	Da		20c. Location	n - City or 7	Town, State
ti K	t. Pag trment tent: ijury c		`4 □Donation 5 🔀	Other (Specify)	7 Entombment		od Cemeter		8/17/0	4	Parkv	ille, I	MD
Starkey Baltimore,	permit. Pages 1 Department of F Importent: If ite eny injury or ot		21. Signature of Funera	I Service Licens	see William (G. Dau	22. Name and		Leon	ard J. I	Ruck, In	c. Fun	eral Home
75	1000		23a. Part1. Enter the di	sease, or comp	lications that cause	ed the death. Do n	ot enter the mode	of dying, su	nd Rd., Ba	Itimore, respiratory ar	MD 21	214	Approximate
	Physician		Immediate Cause (Fina disease or condition	-	Se on each	ime.							Interval Between Onset and Death
	/Medical Examiner		resulting in death)		A Due to (or as	s a consequence o	p: .						
d		_	Sequentially list condition if any, leading to immediately cause. Enter Underlying	ons,	b. IVIVE	odysp	10519						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injurthat initiated events	iale 3	Dia to (or as	s a consequence o	r).						
0,	le be executed ysician and e burial-transit		resulting in death) Last		Due to (or as	s a consequence o	f):						
8760,		lical			d								
9 ×	ding p	/Mec	IF FEMALE:		220 If you outcome	of present						→~	
Bo	atten atten I for us	by Physiclan/Med	23b. Was decedent pre- in the past 12 mon 1 \(\superscript{Yes}\) 2 \(\superscript{No}\)	girain	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 ☐ Ectopic preg					ate of deliv Month	very Day Year
o.	it the d by the tached	hysi	9 Unknown		9□ Unknown		(0,000						
s,	w requires that the deatl been signed by the atte should be detached for	by P	Part II. Other significan	conditions co	ntributing to death t	but not resulting in	the underlying cau	se given in	Part I.	23e. Did to	bacco use co	ntribute to f	the cause of death?
ord	v requir been s should	eted								1 🗆 Y	es 2 No	3 Pro	bably 4 Unknown
Jec Jec	e law has b je 2 sl	Completed								24a. Was a autops	sv	. Were auto	opsy findings available ompletion of cause of
Te.	i icien : Th certificate rector, pag	e Co	25 18/00 2000 20/00/2011				·····				2LX No	death?	2□ No
<u>=</u>	ding Phystcien: The lav h. After this certificate has funeral director, page 2	0 0	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	-	Hospital: 1 Inpati	ent 2 ☐ ER/Outp	patient 3 DOA	Other	Place of Death (
10	ding Phys n. After this funeral di	T:uc	27. Manner of Death 1 Natural 5 [- Donation	28a. Date of Inju	ury 28b. Tii		Injury at Work?	☐ Nursing Home 28		ow injury occu		ry)
siol	tendir leath. lor: Al	catle	2 Accident	Pending investigation Could not be			М	1 🗌 Yes	2 🗆 No				
Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Certification;	4 Homicide	determined	28e. Place of In building, e	jury - At home, farr tc. <i>(Specify)</i>	π, street, factory, c	office	28	Location (Si City or Town	treet and Num n, State)	ber or Run	al Route Number,
	ospite hours ineral y fillec		29a. Certifier 1	Certifying Phy	sician: To the best	of my knowledge,	death occurred at	the time, da	ite and place, and	d due to the c	ause(s) and m	nanner as s	stated
	the Ho hin 24 the Fu	ledical	one)	- Lxaiii	ner: On the basis of and manner st	n examination and	or investigation, in	my opinion	, death occurred	at the time, d	ate and place	and due to	o the cause(s)
	To To Corr	Σ	29b. Signature and title	of certified	w/		29c. L	icense num	_	2	9d. Date sign	1 ,	
	~	-	30 Name and odder		Y	d	1+	100 6	1402		B	141	04
	8		30. Name and address of	Vana (9000 Fr	ANILLY	YPO, Print)	Drive	Roll:	more	MD.	2122	5
	Sta	_	31. Date filed (Month P	Year)		rar's Signature	Acuic)	VIIVE.	Call	111016	1110	10	, ,
	Registra	ar	0	-T 1 70	104 200	pera	9 1						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For Stata Ragistrar	State of Maryla		artment of rtificate of			Rag. No. 2	25766
>	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last, GLADYS C. STAV 4a. Facility Name (If not institution, give THE WESLEY HOM	ELY street and number)			or Location of De	2. Date of De Month	Day Year Solution 4c. County of Dec	4 11:46 AM
	Funeral Director		5. Social Security Number 6. Sec		:. last birthday) Yrs.	If Under 1 Year Months Days		s. 8. Date of Bir Month, Di		rthplace (State or Foreign country) RYLAND
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show amy injury or other traumatic event, the Medical Examinar must be multied at ance.	Completed by Funeral Director	10a. State MD 10e. Street and Number 2211 WEST ROGE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	RS AVE 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. 1	IMORE 10f. Zip Code 21200 Was Decedent of if Yes, specify Cuil 1 Yes 2 Not with done on NOT use retin	Hispanic Origin? ban, Mexican, Pue Specify: spation a during most of w		10g. Citizen of What C USA 14. Race - Am Black, Wh Specify: WF	erican Indian, ite, etc. IITE
Maryland 21	ould be filed w Mental Hygier serked other th	To Be Cor	17. Father's Name (First, Middle, Last) CHARLES WALTER	COOPER		CHER	LILLI	E C. WR		
Baltimore, Mai	permil. Pages 1 and 2 st Department of Health and Importent: If itam 27 is n any injury or other traun <u>once</u> .		19a. Informant's Name/Relationship (T) HARRIET BODE (C) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	OUSIN) 20b. Removal from State UN	Place of Dispo cemetery, crem ITTY W.	TROUT sition (Name of natory or other pla ASHINGT Name and Addr ENRY W.	FARM R ace) ON 08/ ess of Facility JENKI	D JARRE Date	20c. Location - City of HURLOCK,	, MD21084. Town, State
8760,	Cate be executed Medical Examiner Street burial-transit	Ilcal Examiner	23a. Part 1. Enter the disease, or complishook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ications that caused the deane cause on each line. a	rith. Do not entered by the second of the se	er the mode of dy		ac or respiratory a		Approximate Interval Between Onset and Death
P.O. Box 6	the death certifice y the attending pt iched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aidéath 3⊑	Ectopic pregnanc Other (specify)	ey		23d. Date ol de Month	livery Day Year
Records, P	aw requires that the de is been signed by the 2 should be detached	Completed by PI	Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause gr	ven in Part I.	1 ☐ '	an 24b. Were a	robably 4 Unknown
Division of Vital Re	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funarel Diractor: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 □ Inpatient 2 □ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nursing	1 ☐ Yes eath (Check only of Home 5 ☐ Resid	rmed? death? 2 ☑ No 1 ☐ Yes	
Divis	lospital or Attal hours after dea unarel Diractol	cal Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Specialsician: To the best of my knar: On the basis of examin	owledge, death	occurred at the ti	ime, date and place	City or Tou	cause(s) and manner as	s stated.
,	To the Hospital within 24 hours a To the Funaral I completely filled	Medical	29b. Signature and title of certifier LUMY COLOR 30. Name and address of person who co	and manner stated.		29c. Licen.	se number > 16619		29d. Date signed (Mont	h, Day, Year)
	Sta Registi		C. VERLARA - SOA 31. Date filed (Month, Day, Year) AUG 1 7 2004	RES 2211 32. Registrar's Sign	W.ROG	ERS AV	E. BAU	INORE, N	40-21209	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Stv1c 2004 8:45 A M August Alfred Thomas /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel 102 Janelin Drive If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number Funeral 1**X**]M 2□ F 63 14, 1941 Baltimore, MD Director 218-36-5053 June Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Glen Burnie Director MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Janelin Drive 21061 USA Funerai 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or Ite 1√7 Yes 2 □ No If Yes, Give Year or Dates: 60-67 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Longshoreman Shipping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen M. Joran Ignatius W. Stylc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a important: If item 27 is any injury or other tran Angela Stylc / Wife 102 Janelin Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Aug 16 2004 Glen Burnie, MD 4 □Donation 📲 Other (Specify) entombment Glen Haven 22. Name and Address of Facility Singleton Funeral Home PA 21. Signature of Funeral Service Licensee York ll. MO1357 1 Second Ave S.W. Glen Burnie, MD 21061 Vanuere 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Day! /Medical Due to (or as a consequence of) Examiner O Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No detached for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 DNo 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 2 PNo funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Yes 22 No 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 11-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel lhe l 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) we 30. Name and address of person who co-pleted cause of death (Item 23a) (T e, Print) 31. Date filed (Month, Day, Year)

AUG 1 7 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	ian	Decedent's Name (First, Middle, Nicholas A		avin		2. Date of De.	3 ¹ ay 2004	1:15 I
/Medi Exami		4a. Facility Name (If not institution, Washington Adv	give street and number) entist Hospi	tal	4b. City, Town, or Location Takoma Parl	of Death	4c. County of Death Montgome	
Funeral Director		231-47-3479	6. Sex 1 X M 2 ☐ F	(In yrs. last birthday) 31 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birl (Month, Da May 17,	th y, Year) 9. Birth Coy 1973 V	place (State or Fore ntry) irginia
a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montg		Oc. City, Town or Lo				10d. fnside City Lin
3a or 28	al Direc	10e. Street and Number 14235 Grand Pro	e Road, apt.#	202	10f. Zip Code 20906		10g. Citizen of What Cou United Sta	
Department of Health and Mental Hygiene. Importent: or Items 23a or 28a-f show importent: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic event, the Medical Examinar must be notified at apprex.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 1☐ Yes 2☒No Specify		- 14. Race - Ameri Black, White, Specify: Un	etc.
iene. • then "natur ine Medical	ompleted	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 12	s Education grade completed) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired) Carpenter	st of working	16b. Kind of Business/Ir	idustry
Mental Hyginarked other	To Be C	17. Father's Name (First, Middle, L Martin Slavi	n		Ваз		nson	2000
alth and n 27 Is m er treum		19a. Informant's Name/Relationsh Victoria Slavi		19b. Maili 14	ng Address <i>(Street and Numb</i> 235 Grand Pre	Rd., apt.	er, City or Town, State, Zip 202, Silver	Spring,
neni of He ent: If Iten ury or oth	12	20a. Method of Disposition 1 □ Burial 2 ▼Cremation '4 □ Donation 5 □ Other (Sp	3 □Removal from State	20b. Place of Dispo cometery, cre Chesapea	position (Name of matory or other place) ke Crematory	Aug. 6, 2004	20c. Location - City or To Beltsville,	
Departimport any injury once.		21. Signature of Funeral Service L	icensee	2	Ran and Address of Facil 933 Cist Ave.	and Cremati	on Services	0910
nysician Medical Medical Me prival-transit	llcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any least of innectate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as a o	consequence of):	cardo z com	ikiprios		Onset and Dea
nysicia he bur			23c. If yes, outcome of		⊒Ectopic pregnancy	****	23d. Date of deliv Month	,
/ the attending physicia ched for use as the bu	yslclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 2 4□Pregnant at tir 9□Unknown	ne of death 5	Other (specify)			Day Year
signed by the attending physicia Id be detached for use as the bu	d by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	4 ☐ Pregnant at tir 9 ☐ Unknown		Other (specify)		obacco use contribute to t	he cause of death
has been signed by the attending blie 2 should be detached for use as t	by	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown		Other (specify)	1 🗆 Yas autop perfo	res 2 No 3 Prot an 24b. Were auto prior to co death?	he cause of death pably 4 Ankr ppsy findings avail
ate has been signed by the attending pl page 2 should be detached for use as t	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	4☐ Pregnant at tir 9☐ Unknown ns contributing to death but	not resulting in the u	Other (specify)	24a. Was autop perfor 1 Yes	an symmetry 24b. Were autoprior to codeath? 24b. Were autoprior to codeath? 1 Yes	he cause of death pably 4 nkr pasy findings avail mpletion of cause 2 \(\) No
n. After this certificate has been signed by the attending pl funeral director, page 2 should be detached for use as I	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	2☐ ER/Outpatie	Other (specify) nderlying cause given in Part 26. Plac Other: 4 Ni f 28c. Injury 2	24a. Was autop performed a of Death (Check only of Describer 128d. Describer 1	an sy mad? 24b. Were auto prior to co death? 1 Yes ne) dence 6 Other (Special control of the con	he cause of death pably 4 nkm pasy findings ava mpletion of causi 2 \(\text{No} \)
n. After this certificate has been signed by the attending pl funeral director, page 2 should be detached for use as I	To Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 2 Inpatient 28a. Date of Injury (Month, Day)	2 ER/Outpatie	Other (specify) Inderlying cause given in Part 26. Plac Other: 4 Ni Work? 1 Yes 2	24a. Was autop performed to the control of the cont	an sy 24b. Were auto prior to co death? 1 Yes an 24b. Were auto prior to co death? 1 Yes ane) dence 6 Other (Special town injury occurred town injury occurred town, State)	he cause of death bably 4 Inkr psy findings avai mpletion of cause 2 No
this certificate has been signed by the attending pl ral director, page 2 should be detached for use as I	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	2 ER/Outpatier 28b. Time of Injury At home, farm, st (Specify) my knowledge, deat xamination and/or in	Other (specify) Inderlying cause given in Part 26. Plac Other: 4 Ni Work? 1 Yes 2	24a. Was autop performed by the control of the cont	an sy 2 No 3 Protest P	he cause of death bably 4 Inkn ppsy findings avail mpletion of cause 2 No y) Al Route Number, tated.

ORIGINAL

			For State Registrar	State of Mary		artment of H rtificate of L			giene Reg. No. 0 0	25769
	Physici /Medio Examin	an al	1. Decedent's Name (First, Middle, 1. Decedent's Name (First, Middle, 4a. Facility Name (If not institution,		//	S PRY 4b. City, Town, or	Location of Death	2. Date of De Month		oar 3. Time of Death
	Funeral Director		292-32-3879	Policins C. Sek 7. Age (In	tespitat n yrs. last birthday, 65 Yrs.	If Under 1 Year Months Days	TMU 2 If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da Aug 16	v. Year)	Birthplace (State or Foreign Country) A
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show important: If item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Erac is at trust the notified at ance.	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD 10e. Street and Number 3 2 0 N. Robinson 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Street 12. Was Decedent Ever Armed Forces?			spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specify: Wh	ates American Indian, White, etc.
land 21215-0036	ld be filed within 72 ho ental Hygiene. ked other then "natuic event, the Medical	To Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, L. George Clinton	College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired ation Med	furing most of wor hanic	ne (First, Middle,	16b. Kind of Busin Residenti Maiden Surmarne)	· ·
e, Ma	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic <u>QDCB</u> .		19a. Informant's Name/Relationshi Pauline Pullen/1 20a. Method of Disposition 1 Surial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Survice/E	Daughter B □ Removal from State	320 I 20b. Place of Disp cemetery, cre Cedar Hi	N. Robinson of the control of the co	on Street	Date Aug 9 2004	more, MD 20c. Location - Cit Brooklyn	21224 y or Town, State Park, MD
	Physician /Medical Examiner	lical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	omplications that caused the nly one cause on each line.	e death. Do not en Composeduence of): AC Consequence of):	871/ Gree: ter the mode of dying	n Pastur g, such as cardiad	es Drive	e Baltımo	Approximate Interval Batween Onset and Death Z weeks / weeks
.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy			23d. Date o Month	f delivery Day Year
Records, P	icien: The law requires that the de certificate has been signed by the rector, page 2 should be detached	e Completed by Ph	Part II. Other significant condition 25. Was case referred to medical	s contributing to death but n	ot resulting in the	underlying cause give		1 🗆	Yes 2 No 3[an prior prior dea 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	te to the cause of death? Probably 4 Unknown e autopsy findings available t to completion of cause of th? Yes 2 No
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٥	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical Cer		Physician: To the best of m xaminer: On the basis of ex and manner stated	amination and/or i	nvestigation, in my o	pinion, death occu	urred at the time,	date and place, and 29d. Date signed (A	due to the cause(s)
	St. Regist	ate rar	30. Name and address of person v 31. Date filed (Month, Day, Year) AUG 1 7 20	who completed cause of death of the cause of the cause of t	h (Item 23a) (Type And And Signature	Print) 60 L Sparks	- 001 0 N	Woi Fe	8m	nnore, no 187-9(06

		-	For State Registrar	State of	Maryland		rtment			ınd Me		giene	1001	25770
			Decedent's Name (First, Middle, Last,							2	. Date of Dea			3. Time of Death
	Physicia /Medic		John (NMN) Sowa							2	August			10:19 A ^M
}	Examin		4a. Facility Name (If not institution, give						Location o	f Death		4c	. County of Dea	
			3821 Memory Lane, 5. Social Security Number 6. Sec		Age (In yrs. I	ast hirthday)	If Under	bing	Jaon If Under 2	24 Hrs. A	Date of Birth	h	Harfo	
	Funeral Director			M 2□F	. Age (m yrs. 1		Months	Days	Hours	Min.	Date of Birth (Month, Day July 2	v, Year) ∆	1910 Per	thplace (State or Foreign buntry) nnsylvania
			Usual Residence of Decedent								July 2			
	anylan show	_	10a. State 10b. County			, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Mark	ecto	Maryland Harford 10e. Street and Number			Abingo	10f. Zip	Code				10a. Cit	tizen of What C	
	within 72 hours atter death with the Maryland ene. than "natural", or Itams 23a or 28a-f ehow to Medical Ezami nor must be notified at	Funeral Director	3821 Memory Lane	Apt. A	A			210	009				USA	,
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98	or its	y Fu	1 Never Married 2 Married	1 Yes 2 If Yes, Give	2 □ No		1 🗆 Yes 2		Specify:	,	ou., o.o.,			vhite
8	hours tural',	ed by	3 ☑ Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dat	tes:	16a. Dece	font's Heus	I Occupa	ation			16b K	and of Business	/Industry
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Ma	nd 2 s Ith an 27 is r		Helen Hollandswort		nter						pa, MD		1085	,
re,	s 1 ar		20a. Method of Disposition		20b. P	lace of Dispo emetery, crer	sition (Nan	ne of ther place	e)	Dat	te	20c. L	ocation - City or	Town, State
mo	Page nent c ant: If ury or		† Surial 2 ☐ Cremation 3 ☐ State of the surial 2 ☐ Cremation 3 ☐ Other (Specify)			rison				8-18-0	04	Ow:	ings Mi	lls, MD
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 is marked any injury or other traumatic a <u>once</u> .		21. Signature of Funeral Service Licens	Mer	cele	N	IcComa	is Fi	s of Facility	1 Home	e, P.A	·	n, MD 2	1000
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al H											1 Yes	2 Z No		2 2 No
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ior	Attending For death. actor: Atter by the tuner	atio	1 Natural 5 Pending 2 Accident Investigation				М		Yes 2					
Division	or Attendate attendate death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place	of Injury - At ho ig, etc. <i>(Specif</i>)	ome, farm, sti y)	eet, factory	, office		28	of. Location (S City or Tow			ural Route Number,
	To the Hospital or Att within 24 hours atter d To the Funaral Direct completely tilled in by 1	Medical Co	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exem	vsician: To the iner: On the ba and mann	sis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	d place, an th occurred	d due to the o	cause(s date an	i) and manner a d place, and du	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1 1			290	. Licens	e number	=2		29d. Da	ate signed (Mon	th, Day, Year)
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1	/		30. Name and address of person who of SPNABITU		of death (Item		Print)	2	1, m	020	v~	M	0 21	993
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	Regist	rar	1.00 1 1 200	T	nev	Ø	100	the	1					

Amend item/ 1982 Type or Printin Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1216 2004 **Physician** Smith Mae /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number Examiner Cri Baltomore General If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 - M XX Director 409-58-6317 67 21 37 VA 07 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at 2008. 1 XYes 2 No Directo MD Baltimore NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3704 Clarks Lane 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ ₩idowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) House 8th grade Home Maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Bennie Jefferson Corine Brown 1957049 Clarks filed and Number fuel Route Humber Size Town, State, Zip Code) 19a. Informant's Name/Belationship (Type Print)
WILLIAM C Smith Son Callow Ave, Daltimore, Md 21217
ion (Name of Date 20c. Location - City or Town, State Tracy Smith-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 8/17/04 Glen Eurnie, Md 22. Name and Address of Facility
March F/H West 21. Signitur of Funeral Service Licenses 4300 Wabash Ave, Baltimore, Md nus 23a. Part J. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final 40 Eardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Superitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): the attending physician at ned for use as the burial-t of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ld be detached fo 1 ☐ Yes 2 ☐ No 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗀 No 3 Probably 1 ☐ Yes been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page ormed? 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after use....
To the Funeral Diractor: A death. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ,C M.D 4aams 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2004 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician losella Dingheld 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner g of WD Shock Drawno uversity If Under 24 H/s. 8. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 1□M 25 F 077.22.0915 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County NIA 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic event, the Medical Example; must be motified at 1 Des 2 No Director Himor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA Arunan 21216 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 To If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-0036 þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic 13 HousewiFe 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth any injury or other treumatic event QDRB. Trinson illiams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3alto, MD alalo Idustrian 3040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 **①** Cremation 3 ☐ Removal from State 22. Name and Address of Accility * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Jessy, PA 18434 1232 Mid-Valley Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest short or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cesamton **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-transit CERTIFICATION APPROVED BY MED Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medical the attending p use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached 9 Unknown Š been signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes cate has been sig , page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To Yes 2 ER/Outpatient 3 DOA 2 No this 28b. Time of Injury 28d. Describe how injury occurred 28c. 27. Manner of Death injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident
3 Suicide 07.24.04 8:00p^M down Star within 24 hours after death To the Funerel Director: Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🔲 Homicide ome 2745 Willaus Ave To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number D 0061862 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier waler uso AMES G. CUSHMAN UNIVERSITY OF MANyland, Shock TVAVMA Center, BALTIMONE, 32. Registrar's Signature State Registrar 7 2004

				1 - For State Registrar	State	of Ma	arylan	-	artmen ertificat				ental Hy	giene	$n \cap c$		25	773
		Physic		1. Decedent's Name (First, Midd Elizabeth Emm									2. Date of De Month AUGUST	Day		Year		of Death
		/Medi Examir		4a. Facility Name (If not institution	on, give street and i	number)			4b. City,	Town, or	r Location o		100031		County o	CCH of Death	. ~	
				ST AGNES 1	TALTH	CAR	E.		BA	LTI	MOR							
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1-		To tha Hospital or Attandwithin 24 hours after death To tha Funaraf Director: completely filled in by the	Medical	29a. Certifier 1 Certifyi (Check only 2 Medica one)	ng Physician: To t Examiner: On the and ma	ne best of basis of anner sta	examinat	wiedge, deat ion and/or in	n occurred ivestigation	at the tim , in my of	ne, date and pinion, deat	d place, ar th occurred	d at the time,	cause(s) date and	and mann place, and	ner as sta d due to	ited. the cause(s)
_		To tha within 2 To tha comple	Me	29b. Signature and title of certific					290	. License	a number			29d. Date	signed (Month, E	ay, Year)	
				> Mary Pri	1854					>17	608	•		AUG	13	200	· 4 .	
	10			30. Name an address of person					Print)	-200	7						-	
	U			DR. JACKSON, 31. Date filed (Month, Day, Year				BALTIN	MORE,	MI	> - &	2122	9.					
		Sta Registi		ALICA 7 200	/	Hegistra	ar's Signal	5 0	pork	2/								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #2 PER PHY C834 8925 1602 at 911 Death Reg. No. 2. Date of Death AUG 15, 2004 1. Decedent's Name (First, Middle, Last) **Physician** Myrtle Elizabeth Ione Timmons $\frac{16}{2004}$ August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2<mark></mark> F 216-12-6516 Yrs Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1411 Superior Street 21078 USA Funera 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 Yes 2000 ⋧ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Cashier Grocery Store othar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental William Edward Griffith Bertha Emma 2 Coulter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Howard E. Timmons/Son 1411 Superior St., Harve de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department or important: If any injury or once. '4 □ Donation 5/□ Other (Specify) Mt. Carmel Cemetery Bel Air, Maryland 21. Signalure of June al Service Licensee ²² Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Plant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oke **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 3 10 1 ☐ Yes 2 ☐ No 1 Yes to the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funeral I
completely filled

Timmons, Division of Vital Records,

> State Registrar

Leticia 31. Date filed (Month, Day, Year) AUG 1 7 2004

29b. Signature afjd title of certifier

a alm

29a. Certifier (Check only one)

> S. Jalvez M.D 22. Registrar's Signature

my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D-15994

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

8-16-04

"S, UNION AVE, HAVE DEGRACE

ORIGINAL

Dhycinia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Y	ear G. Time of Death
Physicia /Medic		ALEKSANDR	VEKSHTEYN		UGUST 1	3 2004	10:38 P ^M
Examin	er	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL	4b. City, Town, or BETHESDA	Location of Death		4c. County of	
ıneral		5. Social Security Number 6. Sex 7. Age (In yrs. last I	oirthday) If Under 1 Year	If Under 24 Hrs.		MONTGOM	Birtholace (State or Foreign
ctor		213-37-8273 X□M 2□F 82	Yrs. Months Days	Hours Min. 1	3. Date of Birth 2/26/192	Î'	Country UKRAINE
e natified at	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location				10d. Inside City Limits
7	ctor	MD MONTGOMERY CHEVY	CHASE				1 Tesx 2 No
orgal Examiner must be notified at	Director	10e. Street and Number	10f. Zip Code			Citizen of Wha	at Country?
	Funeral	4700 BRADLEY BLVD. APT. 210 11. Marital Status 12. Was Decedent Ever in U.S.	20815	Spanic Origin? (Span		.S.A.	American Indian,
		1 ☐ Never Married	13. Was Decedent of Hi If Yes, specify Cuba		ican, etc.)		White, etc.
	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	WHITE
	olete	(Specify only highest grade completed)	 Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired) 	luring most of working	166	. Kind of Busin	ess/Industry
	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 5+	CHANICAL ENGI	•		TRUCKI	NG
	Be	17. Father's Name (First, Middle, Last)	LITE VAL	18. Mother's Name	First, Middle, Mai	den Sumame)	Unobtainable
	2		HTEVN b. Mailing Address (Street a	And Number or Rural	Route Number, Ci	- One	DIATIMEDE
other traumatic		GREG VEKSTEIN / SON 3	842 BEECHER S	STREET WAS		-	
5			of Disposition (Name of ery, crematory or other place				y or Town, State
		*4 Donation 5 Dother (Specify) UHIZUK 21. Signature of Funeral Service Licensee	AMUNO CONG. 22. Name and Addres	08/15/		LTIMORE	
any Injury or of once.		AcotoM. Cuther	8900 REISTE				
		23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.	not enter the mode of dying	g, such as cardiac or	respiratory arrest,		Approximate Interval Between
ian ical		Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST					Onset and Death
ner		Due to (or as a consequence b CORONARY ARTER	•				
70	iner	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence					
he burial-transit	Examiner	Cause (Disease or injury that initiated events c. H V ARDI resulting in death) Last Due to (or as a consequence					
	ical	d CONGESTIVE HEA	RT_FAILURE				
of for use as t	Physician/Med	IF FEMALE: 23c. If yes, outcome of gregnancy			_		
d for u	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date o Month	f delivery Day Year
be detached	hys	9 □ Unknown					
90	þ	Part II. Other significant conditions contributing to death but not resulting MYASTEMA GRAVIS	in the underlying cause give	en in Part I.	23e. Did tobacc	V	te to the cause of death? Probably 4 Unknown
pinous	Completed	DIABETES			24a. Was an		e autopsy findings available
page 2	Com				autopsy performed	? prio	r to completion of cause of
director, page 2 s	Be	25. Was case referred to medical examiner?		26. Place of Death (A		
ral dir	2	27. Manner of Death 28a. Date of Injury 28b	Outpatient 3 DOA Othe	4 Nursing Home	e 5 Aesidence		Specify)
e fune	ation	27. Manner of Death ▼□Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	Injury Work	(? Yes 2 □ No	d. Describe flow in	ijary occurred	
n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28	f. Location (Street City or Town, St	and Number o	or Rural Route Number,
iilled ii		29a. Certifier X Certifying Physician: To the best of my knowled	go doeth occurred at the time	and the second place are second			
>	edical	29a. Certifier (Check only one) X Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigation, in my op	pinion, death occurred	d at the time, date	e(s) and manne and place, and	or as stated. due to the cause(s)
elele	ž	29b. Signature and title of certifier	29c. License	number		-	fonth, Day, Year)
complete						// //.	
To the Funaral Diractor: Aller this certificate he completely filled in by the funeral director, page)	D 96	5309	0	18-14.	- 2004

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	ate of Maryland / [Department of Certificate of			ene g. No.?	25776
	Physici	an	Decedent's Name (First, Middle, Last) ATMA LIETTED				2. Date of Death Month	Day Year	3. Time of Death
	/Medic		ALMA WEILER 4a. Facility Name (If not institution, give street	and number)	4b. City, Town	, or Location of Death	08	11 2004 4c. County of Death	11:40 P M
	Examin	eı	MARINER HEALTH OF F	•		T HILL		HARFOR	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2	7. Age (In yrs. last bir	thday) If Under 1 Yea Months Day		8. Date of Birth (Month, Day, Jan. 27	9. Birth	place (State or Foreign intry) aryland
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	Mary P-f sh	tor	Md. Harford		Fore	st Hill			1 ☐ Yes 2 🛂 No
	th with the 23a or 28 at be not	al Director	10e. Street and Number 1615 Creston Drive		10f. Zip Code	21050	10	g. Citizen of What Cou United St	•
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28a-f show of other than "natural", or Itams 23a or 28a-f show event, the Medical Evantinal must be notified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U.S. med Forces? _Yes _2	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (Spe uban, Mexican, Puerto to <i>Specity:</i>	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036	filed within 72 he Hygiene. Vthar than "natu ant, the Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) 8 years	pleted)	Decedent's Usual Occ (Give kind of work don life. DO NOT use reti nomemaker	cupation ne during most of worki ired)	ng 1	6b. Kind of Business/le	ndustry
yland 2		To Be C	17. Father's Name (First, Middle, Last) Charles F. Lutche, S	r.		18. Mother's Name Elizabe	(First, Middle, Ma th Gleit		
Jar	and and s m		19a. Informant's Name/Relationship (Type, P		. Mailing Address (Stre				
	s 1 and 2 of Health item 27 other tra		Pam Sizer/daughter 20a. Method of Disposition	20b. Place of	1615 Cresto f Disposition (Name of	T 0		Oc. Location - City or T	
mor	Pages ent of ht: If it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)		ry, crematory or other p ns of Faith			altimore,	
Baltimore,	permit. Pages. Department of H Important: If ite any Injury or of		21. Signature of Funeral Service Licensee	le		dress of Facility Inek Funera MacPhail			Inc. 21014
	Pnysician /Medical Examiner	_	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	use to (or as a consequence	not enter the mode of d	lying, such as cardiac o	r respiratory arres	st,	Approximate Interval Between Onset and Death
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rds, P.	The law requires that the tte has been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributed	ing to death but not resulting i	n the underlying cause	given in Part I.	23e. Did toba	acco use contribute to	'\
Il Records,		Completed					24a. Was an autopsy perform	ed? prior to co	opsy findings available impletion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al·		26. Place of Death			
of	ding Phys h. After this funeral di	tlon: To	1 185 2 190	a. Date of Injury 28b.	Time of 28c. In Injury	4 Nursing Hor	me 5 🗌 Residen 28d. Describe how	nce 6 □Other (Speci v injury occurred	fy)
Division	i Diffe	Certification:	2 □ Suicido 6 □ Could not be	e. Place of Injury · At home, fa building, etc. (Specify)	arm, street, factory, offic	ce	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospital within 24 hours (To the Funeral completely filled	edical	(Check only 2 Medical Examiner: (To the best of my knowledge on the basis of examination and and manner stated. 	e, death occurred at the nd/or investigation, in m	time, date and place, a y opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To the He within 24 To tha Fe completel	Me	29b. Signature and title of certifier		29c. Lice	ense number	296	d. Date signed (Month,	Day, Year)
			Day S Du		9	32255	A	DUGUST 1	3, 2001
4			30. Name and address of person who comple					*	,
,)	- 722		DAVID S. DUNN 61 31. Date filed (Month, Day, Year)	5 W. MacPHATL 32. Registrar's Signature	ROAD, BEL	AIR, MD 2	1014		
	Sta Regist			Server &	Sparks				

		,	For State	State of Ma	arylan		artment of I		ınd M	•	20	01.	05777
	Ţ.		Registrar 1. Decedent's Name (First, Middle, Last)			061	lineale of	Dealii		2. Date of Dea	Reg. No. U	UH	3. Time of Death
П	Physicia		Dorothy	Eva	Wł	nite				Month August	16. 20	Year 104	8:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give s				4b. City, Town,	or Location of	f Death		4c. County		
		4	1638 Myamby Roa	ıd			Tow	son				Balt	imore
	Funeral		5. Social Security Number 6. Sex	7. Ag		ast birthday)	If Under 1 Year Months Days		Min.	8. Date of Birt. (Month, Day MAR 3,	h v, Year)	9. Birth	place (State or Foreign intry)
	Director		212-16-3323 Usual Residence of Decedent		94	Yrs.				MAR 3,	1910	Maı	cyland
	ow ow		10a. State 10b. County		10c. City	, Town or Lo	cation					1	10d. Inside City Limits
	Many a-f sh ilied	tor	Maryland Baltimo	re			Towso	n				İ	1 ☐ Yes 2X No
	th the	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	untry?
	23c c	ral	1638 Myamby Roa	ıd				21286)		USA	A	
	tems	Funeral		Was Decedent Armed Forces?		S. 13. \	Was Decedent of f Yes, specify Cut	Hispanic Origon, Mexican,	in? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. Rad Bla	ce - Amer	ican Indian, etc.
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉	No	1	1☐Yes 2 X No					y Wh	
9	within 72 hours after death with the Maryland ene. then "neturel", or Items 23c or 28a-f show the Medical Examiner must be notified at	edt	15. Decedent's Educ	Year or Dates:		16a Decer	lent's Usual Occu	nation			16b. Kind of B		
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nd	be filed within 72 hours after death with the Marylan ntal Hygiene. od other then "naturel", or Items 23c or 28a-f show event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle,	Maiden Suman	ne)	
<u>yla</u>	2 should be and Mental resumatic every	은	Harry Eugene Va			,				aria S			
Maryland 21215-0036	s 1 and 2 should if Health and Mer item 27 Is marke other treumatic		19a. Informant's Name/Relationship (Ty)		_		g Address (Stree						
	1 and Healt em 2 ther		Barbara A. Wollsla 20a. Method of Disposition	iger/Daug			B Myamb sition (Name of	y Roa		Towson	20c. Location		
nor	ages ont of t: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ce	ametery, cren	ematory or other pla ematory,	,			Baltin	-	
altimore,	permit. Pages 1 and 2 Department of Health s Importent; If item 27 th eny injury or other tre once.		21. Signature of Funeral Service License	e //	1100								, FID
ñ	Depa Impo eny ii		Edward A Gr	egorchi	k	20	remardado 99 Fred	n Soc erick	1et	y of M	D, Inc	. M	D 21228
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused	the death			ing, such as o	cardiac o	r respiratory ar	rest,	, 11	Approximate Interval Between
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	/Medical Examiner	į.	resulting in death)	Due to (or as	a consequ	uence of):	1					-	
E	LAdillitiei	l.	Sequentially list conditions, b	- Leci	Jbit		cers						
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	al-trai	Exar	that initiated events cresulting in death) Last	Due to (or as	a consequ	uence of):							
8760,	cate be executed physician and the burial-transit	dical											
9	tificat ng phy as th												
Вох	death certific e attending pl id for use as t	an/h	230. Was decedent pregnant	3c. If yes, outcome 1□Live birth			Ectopic pregnanc	ev.				te of deliv	•
		Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (specify) _	,			Mo	onth	Day Year
P.0	t t	Phy	Part II. Other significant conditions con	tributing to death h	ut not resi	ulting in the ur	adarhing cause a	von in Part I		23e Did to	hacco use cont	ributo to t	the cause of death?
ds,	ng pa	d by		anoding to dodino	di noi 1630	aking in the di	idenying cause gi	veirii raiti.					bably 4 Unknown
Sor	> 4 0	ete								24a. Was a			
Vital Records	The law ate has b page 2 st	Completed								auton	med	death?	opsy findings available ompletion of cause of
tal	en: The tificate tor, pag	a	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only or		1 🗆 Yes	2□ No
	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 🔲 Inpatie	ent 2 🗆 I	ER/Outpatien	t 3 DOA Ot	hac			ence 6 □Oth	er (Specia	fv)
n of	ng Ph fter th neral		27. Manuer of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	28c. Inju				ow injury occur		
Sio	Attending r death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□N	lo				
Division	l or Att after d Direct J in by	Certification:	4 Homicide determined	28e. Place of Injuding, etc.	ury - At ho c. <i>(Specify</i>	me, farm, str	eet, factory, office		2	8f. Location (S City or Tow	treet and Numb n, State)	er or Run	al Route Number,
	e Hospitel 24 hours a e Funerel D etely filled i		29a. Certifier 1 Certifying Phys	ician: To the best	of my know	wledge death	Localized at the t	imo data and	I place o	ad due to the e			
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examinate)	ner: On the basis of	r examinat	tion and/or inv	estigation, in my	opinion, death	h occurre	d at the time, d	late and place,	and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and talle of certifier				29c. Licen	se number		2	29d. Date signe	d (Month,	Day, Year)
			1 Theone	- ful			DZ	-556	9		Augus	t 16	5, 2004
1			30. Name and address of person who co	mpleted cause of d	leath (Item	23a) (Type,	Print)	1.01	/11	11/14	/ 1//	M	1 31003
ŗ)		Francis Wiegr 31. Date filed (Month, Day, Year)	nann /	Y Signat	1/20	100 CC	eva	1 11	II LUIN	EIVITE	1 16	9-212
5	Sta Registr		MIG1 7 2004	Comer	ar s digital	A	Sports	/ ′		/			

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #5 PER FH G835 9/29/10/40/2019 of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08/13 / 2004 **Physician** JOHN KRANTZ WHITE 5:25 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19 DERWOOD CT. PARKVILLE BALTIMORE 5.218-328-y6635 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/29/1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 212-28-6635 XXM 2□F 72 Yrs. Director MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner matcher notifies at MD BALTIMORE PARKVILLE Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 DERWOOD CT. 21234 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite Affiliad Forces : 1 X Yes 2 □ No If Yes, Give Year or Dates: 1950 S 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Completed by Specify: WHITE 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired during most of working Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE VICE PRESIDENT INSURANCE 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH MCCURLEY WHITE JR. JANET TAYLOR KRANTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra ALAN WHITE 1107 HIGH COUNTRY RD. TOWSON, MD. 21286 son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State GREEN MOUNT 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 08/14/2004 BALTIMORE, MD. ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD. 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladd Priysician 8 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death Year 5 Other (specify) 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Unknown ate has been si page 2 should h 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 \(\text{Nursing Home} \) 1 □ Yes 2 No. 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 Sidence 6 ☐Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending P
 24 hours after death.
 Funerel Director: After the Certification: Injury 1 Matural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maliner as a linear 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D0056919 Enleun 30. Name and address of casen who can pleted cause of death (Ijem 23a) (Type, Print) Charles st. PAN West #205 Baltmone Mo 670 82. Registrar's Signature AUG 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOSEPH 5. Social Security Jumber HOSPICE 7. Age (In yrs last birthday) 10 more of the state If Under 1 Year 9. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth A (Month, Day, **Funeral** Days Months Hours Min. 7-68-2313 1 ☐ M 2 🔯 F Director lenne Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Exertinar must be notified at Maryland
10e. Street and Number Director 1 XYes 2 No more 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify. þ 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry oemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 ts marked other than ' College (1-4or 5+) etak er 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 0 deric 19a. Informant's Name/Relationship (Type, Print) (caugites) 19b/Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 12004 Injury or 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Balto. Joseph L. Russ F. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. nter the disease, or com or heart failure. List only Approximate Interval Between Onset and Death Immedia Cause (Final disease or condition resulting in death) Physician COMOS /Medical Due to (or as a consequence of): Examiner 2-3 WLS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due tr (or as a consequence of): physician and s the buriaf-transit as a consequence of): Physician/Medical 204r IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 🗆 No 1 Yes of Vital 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 105 MCC 1 ☐ Yes 2 No 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Atter To the Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely tilled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar St

N. Eu Jaw

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 1 7 2004

HOSPICE

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:47 AM 10 2004 1101/ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Izabeth im en a UVS N/A Ina OL If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Yeer) **Funeral** Days Min. 1 M 2 4 F 217-20-2200 Yrs. 78 25, 1926 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location od 2 should be filed within 72 hours after death with the Marylan thin and Mental Hygiene. 27 is marked other than "naturel", or Itema 23a or 28e-f show treumatic event, the Modical Examine must be multiped at No 2 No Director Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1011 Rockhill Ave. 21229 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) and 2 should be Carroll George Moffett Viola Ameila Schultheis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2.
Department of Health at Important: If item 27 is eny injury or other treughter. Jeffrey C. Welden (Son) 306 Westowne Rd., Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 8/16/04 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licenses 3620 Wilkens Ave., Baltimore, MD 21229 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to for as a cons * uence of): Examiner tive moriory di Ironi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit death certificate be executed 10/2 19 ear Due to (or as a consequence of): Box 68760, Physiclan/Medical detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the 9 Unknown been signed by to should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐Yes 2☐No 1 Yes or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 2 No Other: Nursing Home 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) ٩ this within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral. 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury Natural 2 Accident 5 ☐ Pending 1 Tes investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO ,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) am d 227 Mina 352 0 enson venue imore 32. Registrar's Signature 31. Date liked (Month, Day, Year) State Registrar 7 2004 MIGT

State of Maryland / Department of Health and Mental Hygiene State Registramend ITEM #5 PER FH G835 9/09/404/fignate of Death Reg. No. U 2 Date of Death 3. Time of Death **Physician** 5:50 A M Weaver August 12 2004 .Tohn Mason /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Mariner Health of Silver Spring If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 73713941177998 **Funeral** Months Days Hours 1X M 2 F 82 Yrs. 1922 152-14-2992 May 20, Missouri Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or itema 23e or 28a-f shov tre Medical Exeminer must be notified at 1 ☐ Yes 2 X No Silver Spring Maryland| Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 United States 10313 Pierce Dr. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 XYes 2 □ No If Yes, Give Year or Dates: W W II 1 Never Married 2 Married Baltímore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) 5+ Federal Government Librarian other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any light or other treumatic event once. Be Weaver Marjorie Calender Ernest M. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10313 Pierce Dr., Silver Spring 20901 Irma Weaver / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition August 13 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 2004 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1.5 years Physician Cerebrovascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unsease or injury that initiated events Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Aspiration Pneumonia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Ventilatory Failure 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 Yes 2X No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number D09834 August 12, 2004 Rose 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Rosenbaum M.D.; 3720 Farragut Ave., Kensington, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2004

			1 - For State Registrar	State of Mar		artment of		and Mental H	ygiene	nol.	25782
	Physici	an	1. Decedent's Name (First, Middle, CALVIN WOOD					2. Date of I	Death Da	y Year	3. Time of Death
).	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town,	, or Location	AUGU of Death		2 ZOG	
	Exami		UNIVERSITY OF MARY			BALTI				NA	
	Funeral Director		5. Social Security Number 6 218-12-3654 Usual Residence of Decedent	Sex 7. Age (10 11 12 11 11 11 11 11 11 11 11 11 11 11	In yrs. last birthday) 79 Yrs.	Months Day		24 Hrs. 8. Date of E Min. Sep 1	Birth Da <i>y, Year)</i> 9 , 19	9. Birth Co 24 Mar	thplace (State or Foreign buntry) Yland
	yland sow		10a. State 10b. County	1	0c. City, Town or Lo	ocation			-		10d. Inside City Limits
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	with th	Dire	10e. Street and Number			10f. Zip Code				tizen of What Co	
	ns 23	eral	432 Seward Avenu	12. Was Decedent Eve	er in U.S. 13.	21225 Was Decedent of	f Hispanic Ori	gin? (Specify Yes or I		ted Sta	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show amy njury or other traumatic avant. It is Madical Examiner must be notified at ance.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 € Yes 2 □ No If Yes, Give Year or Dates: 4 3		If Yes, specify Cu 1 ☐ Yes 2 🗷 N	ıban, Mexicar	n, Puerto Rican, etc.)		Black, White Specify: White	
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Maryland	uld be Vental Irkad	To B	Harry Washingto	n Wood			Anna	Gray			
Man,	2 sho and I is me		19a. Informant's Name/Relationship					er or Rural Route Nurr			·
	1 and Health am 27 ther t		Mrs. Lena Wood/V		20b. Place of Disponentery, crei			Brooklyn Date	, ,	, MD 212 ocation - City or	
JOE L	Pages ent of nt: ff it ry or o		1 Burial 2 Cremation 3	HIGHIOVAL HOLL STATE	cemetery, cree Chesapea		1	Aug 14 2004		tsville	
Baltimore,	permit. I Departm Importar any inju		21. Signature of Funeral Service Lic		186 22	2. Name and Add Crematic	ress of Facilit	y Funeral Al	Ltern	atives	
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	ate be executed thysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
8760,	oe exe	I Ex	resulting in death) Last	Due to (or as a c	onsequence of):						
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Box (h certii ending	In/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 []Ectopic pregnan	ICV			23d. Date of deli	ivery
	Attending Physician: The law requires that the death certificate be executed refash. sctor: Atter this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Medl	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at tim		Other (specify)				Month	Day Year
S, P	ires that signed b	by	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause g	given in Part I.			use contribute to	the cause of death?
Record	w requir been si should	letec				-		24a. Wa			
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Vital	ysician: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	Hospital:			1th oc	of Death (Check only			
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ion	Attending or death. actor: After by the funer	atlor	1 Natural 5 Pending 2 Accident investigat	(Month, Day Y ion	(ea <i>r</i>) Injury		ork? □Yes 2□	No			
Division of		ertification;	3 Suicide 6 Could not 4 Homicide determine		- At home, farm, str Specify)	eet, factory, office	9	28f. Location City or T	(Street an own, State	nd Number or Ru e)	ral Route Number,
	To tha Hospital or Atteni within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of reminer: On the basis of example and manner stated	camination and/or in	h occurred at the vestigation, in my	time, date an opinion, dea	d place, and due to th th occurred at the time	e cause(s) e, date and	and manner as d place, and due	stated. to the cause(s)
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	1 1	115	29c. Licer	nse number		29d. Dat	te signed (Month	n, Day, Year)
•	.\		> Day	ncalculoss	1 M	P1	1774	2	8/	12/04/	AUGUST 12,2004
\	3,		30. Name and address of person what ALAN EUSAKA		th (Item 23a) (Type,	Print) LE STA	eel, 1	BALTIMORE	E, M	ND 21	217
•	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 7 200	3. Registrar's	Signature	sparks	/				

			1 - For State Registrar	State of Maryland		rtment of H		•	giene Reg. No 20 (16 25783
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medi		ROBERT	ALTON	12	ALKEF	2 . 1R	AVGUS	ng*	Year 6:28 P M
	Examir		4a. Facility Name (If not institution, give s	itreet and number)		4b. City, Town, or BALTIM	Location of D	eath	4: 0	
	Funeral Director		5. Social Security Number 6. Sex 219 50 6364	7. Age (<i>In yrs. las</i> 49	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	fin. (Month, Da	th ly, Year) 6 • 1954	Birthplace (State or Foreign Country) Marvland
	D .		Usual Residence of Decedent 10a. State 10b. County	100 City 7	Town or Loc					
	ehov	5								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28e-f	ecto	Maryland Anne Ar	undel Ba:	1timo					
	with	급		Doe d		10f. Zip Code	.=		10g. Citizen of Wi	nat Country?
	ns 23	era	230 W. Edgevale	ROdQ 2. Was Decedent Ever in U.S.	13. W	2122		(Specify Yes or No	U.S.	- American Indian,
21215-0036	s filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Items 23a or 28e-f ehow vent, Ire Medical Executer must be notified at	by Funeral Director	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 12 Yes 2 □ No If Yes, Give Viet Year or Dates:		Yes, specify Cuba ☐ Yes 2X No	Specify:	(Specify Yes or No Jerto Rican, etc.)	Black Specify:	White
Ö	2 ho	ted	15. Decedent's Educ	cation	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bus	
218	within 7 ene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done o OO NOT use retired	uring most of	working		
	ed wi	Con		2 years	True	ck drive			Trucki	
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 Is marked other than "natural other traumetic event, the Madical	Be	17. Father's Name (First, Middle, Last)	7.7- 11 C				Name (First, Middle,		,
Уlа	should be nd Mental marked o	ဥ		. Walker, Sr.				athalie N		
Jar	l 2 sho	1 4	19a. Informant's Name/Relationship (Type Mary A. Walker	oe, Print)				Rural Route Number		
	1 and 4ealth 9m 27 ther t		20a. Method of Disposition	20h Plac		W. Edgeva	те коа	d Balt		aryland 21225
Baltimore,	Mges If ite		1 ☐ Burial 2 X Cremation 3 ☐ Re	emoval from State	etery, crem	atory or other place				ity or Town, State
Itin	it. Partitude		*4 □ Donation 5 □ Other (Specify) 21. Signature of Fineral Service Ucense	Bayv		remation Name and Addres				e, Maryland
Ba	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra QDCe.		Premo (1)	dridge	40	01 Ritch	ie High	way Bal	timore,	vice, P.A. Maryland 21225
7	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	SYSTEMIC		r the mode of dying	_	liac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions, b	Due to (or as a consequent	BP	CTERIA	- (PERITOR	11715	5 DAYS
	ed sit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen			6.0			
	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequen		E LIV	er			2 YEARS
38760,	cate be execut physician and the burial-trar	a E		HEPATITIS	,	_				MORE THAN
587	phy:	edical	d	1.0111111						10 JEHRS
.O. Box (The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 □E	Ectopic pregnancy Other (specify)			23d. Date Monti	
σ.	that the	F.	Part II. Other significant conditions con-	tributing to death but not resulting	na in the und	derlying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
Records,	w requires that been signed be should be det	ted by								☐ Probably 4 Munknown
l Rec		Completed						24a. Was a autop perfor	sy prie med? dea	ore autopsy findings available or to completion of cause of ath? Yes 2 No
Vital	ysician: Th iis certificate director, pag	Be (25. Was case referred to medical examiner?				26. Place of C	eath Check onl or		
of V	Physician: this certific ral director,	၉	1 ☐ Yes 27 No	ospital: 1 ★ Inpatient 2 □ ER	/Outpatient	3□ DOA Othe	r: 4 🔲 Nursing	Home 5□ Resid		
		e :	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury Work	?	28d. Describe h	ow injury occurred	
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				es 2 ☐ No	Tarris 1		
=	s after or Al S after or al Direct ad in by	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my knowleder: On the basis of examination and manner stated.	dge, death of and/or inve	occurred at the time estigation, in my op	e, date and pla inion, death oc	ce, and due to the c curred at the time, d	ause(s) and mann late and place, and	er as stated. d due to the cause(s)
	To ti withi To ti comp	Ž	29b. Signature and title of certified	mp Rey-3		29c. License		2	9d. Date signed (Month, Day, Year)
			111000	מואי		P-11	5775		AUGUST	10 2004
3/			30. Name and address of person who cor	npleted cause of death (Item 23	Ba) (Type, P	rint) ANOVER	RISH	SHAM	TIMORE.	mo-21225
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 7 2004	32: Registrar's Signature	4	Sparks				

			For State Registrar	State of	Marylan		artmen rtificate			and M		Reg. No.	O I.	25784
	Physicia		1. Decedent's Name (First, Middle	Trancis	Bro	41 0					2. Date of De	Day	Year OG	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, Beltimore Roll		er)		_	Town, or	Location				ty of Death	
	Funeral Director		5. Social Security Number 215–18–3422		Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da July 2	10 Year) 2,1924	9. Birthp Gour Ma	lace (State or Foreign iryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Ann	e Arundel		y, Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 No
	vith the	Direc	10e. Street and Number				10f. Zip					10g. Citizen o		ntry?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural; or items 23s or 28s-f show or other traumatic event, the Medical Evander must be notified at	by Funeral Director	452 South Car 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decede Armed Force	ent Ever in U. es?		Was Deced If Yes, spec				ecify Yes or No Rican, etc.))- 14. Ra Bi	J.S.A. ace - Americ ack, White, ify: Whi	etc.
21215-0036	n 72 hor "natura edical L	Completed	15. Decedent (Specify only highes			(Give	dent's Usua kind of wo DO NOT us	rk done d	during mos	t of work	ing	16b. Kind of	Business/Inc	dustry
	ed within 'giene.	Comp	Elementary/Secondary (0-12)	College (1-4	or 5+)		ntena		Mech					I. Corp.
Maryland	ould be filed with Mental Hygiene arked other tha atic event, the	То Ве	17. Father's Name (First, Middle, and Julius Br							Eve1		Maiden Suma Smith	ame)	
Mary	d 2 sho th and N 7 Is ma trauma		19a. Informant's Name/Relations Gloria I. Brown									er, City or Town		Code) ad 21122
	of Health of Health fitem 27		20a. Method of Disposition 1 ■ Burial 2 □ Cremation		20b. F	Place of Disponentery, crea					Date	20c. Location		
Baltimore,	permit. Pages 1 Department of H Important: If itel any injury or ott		* 4 □ Donation 5 □ Other (S) 21. Signature of Fune(al Service)	pecify)		IAR Hil	Name an	d Addres	ss of Facilit	8-21				k, Marylan
Ba	Dep Impo		Jana &	1 Tank	nM	Mo	Cu11; 3204_1	y-Po. Iouni	lynia tain	k Fu Road	, Pasac		A. arylar	nd 21122
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	aa	h line.	ager			g, such as	cardiac d	ung	rrest,		Approximate Interval Between Onset and Death
9760,	be executed ician and burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either University of Cause (Disease or injury that initiated events resulting in death) Last	С.	as a conseq									
.O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2 ∏Feta nt at time of d	I death 3	⊒Ectopic pi ☐ Other (sc						Date of delive	ery Day Year
0	Se de	by	Part II. Other significant condition Chronic L	ms contributing to dea	th but not res	7	inderlying o					tobacco use co Yes 2 No		ne cause of death?
Records,	The law ate has b page 2 sl	Completed		// (<i>f</i>						24a. Was auto perfo 1 Yes		. Were auto prior to co death? 1 \(\subseteq Yes	psy findings available mpletion of cause of
Vital	sician: certifical	o Be (25. Was case referred to medical examiner?	Hospital:	patient 2	ER/Outpatie	nt 3□ D0	Othe			h (Check only o	one)	ther (Specif	ivi
Division of	Attending Physician: r death. sctor: After this certifici	\vdash	27. Manger of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date of (Month,		28b. Time of Injury		8c. Injun Worl				how injury occi		y)
Divisi	i or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 6 Could determ	not be 28e. Place o	f Injury · At h	ome, farm, st	reet, factor	y, office			28f. Location (City or To		nber or Rura	d Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		g Physician: To the b Examiner: On the bas and manne	is of examina									
	To the within 2 To the I complet	Me	29b. Signature and title of certifie	. Cal		<u>ب</u>			e number	(OH	(0)	29d. Date sign		Day, Year)
	KI		30. Name and address of person Tohn S. LAH.M.	who completed cause 3900 Loca	of death (Iter	m 23a) (Type	Print)	d, B	Beltin	100	Marul	and 21.	2/8.	
26	Sta Regist		31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signa	ature	Spa	Kr	,			and 21.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 12:10A M Jean Piver BASS August 15, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3310 N. Leisure World Blvd. #815 Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 83 Yrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 □ M 2 🛛 F Director March 22. 056-16-8696 1921 Russia Usual Residence of Decedent 10a. State Maryland 10b.County Silver Spring 10c. City, Town or Location Montgomery 10d. Inside City Limits 28a-f show r than "naturel", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 3310 N. Leisure World Blvd. #815 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2) No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other treumatic event, the once. 12 Procurement Clerk U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Podolsky Sophie Wexler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3310 N. Leisure World Blvd. #815, Silver Spring, Solomon Bass/ Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Slate Lebanon Cemetery August 17, 2004 Mt .ce 1 Burial 2 □ Cremation 3 □ Removal from State Adelphi, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liousee

22. Name and Address of Facility
Torchinsky Hebrew Funeral Home
234. Carroll Sc. 20012

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** SC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ cate has been sig , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy performed? Yes 2 No 1 🗌 Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification; To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours after To the Funeral Direct 0 To the Hospital 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number son who completed cause of death (Item 23a) (Type, Print) EVST MD 10810 31. Date filed (Month, Day, Year) AUG 1 8 2004 32 Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

State

29b. Signature)and

Elliott Corbaty, MI 31. Date filed (Month, Day, Year) AUG 1 8 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Division of Vital Records, P.O. Box 68760,

1411 Madison

32. Registrar's Signature

29c. License number

0200094

Park Dr #2B Glen Burnic MD. 21061

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.... 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Month **Physician** BLUMER AUGUST JILLIAM. Hook /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** GREATER BALTIMORE MEDICAL BENTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Months Days Hours Min Director 098-19-9262 NEW OCT 30 1921 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits or then "neturel", or Items 23e or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MARYLAND BALTIMORE ARNEY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code D.S.A permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s any injury or other treumatic event, the Madical Examinar mutal. 2018. 8700 14000 31334 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1-∰Yes 2 □ No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WITHU Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 127RZ-ANABER SARG 178 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HINRY BLUMZR KSSGAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARREY MARIL G. BLUMER BU ON ATHLORD CAON O. BAKSAL" Avecar 18 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2004 MALERA KW000 Ismeter 22. Name and Address of Facility
EVANCEY ACETO FOR KOFO PERKYILLE.
8800 HARFORD KOFO PERKYILLE. 21. Signal are at Fun at Service Licens 21234 1ARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma -UN9 Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and ched for use as the burial-transit Physician: The law requires that the death certificate be executed ereboursen/in Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4-Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: To the Hospitel or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUGUST 14, 2004 30. Name and address of terson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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			1 _ Stata	State of Marylar	•	artment of I rtificate of		nental Hyg	iene 2001.	25700
	_		Registrar 1. Decedent's Name (First, Middle, Last)		Ce	runcate or	Dealli	2. Date of Deat	eg. No U U 4	2. J / O C
	Physici /Medio		NELLIE		COAN			Month August	Day Year	
	Examin		4a. Facility Name (If not institution, give s	6 24 1 1		4b. City, Town,	or Location of Death Burnie	2	Anne A	irundel
	Euporal		5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.			
à.	Funeral Director			M 2 X F 8		Months Days	Hours Min.	8. Date of Birth (Month, Day, July 21	,1915	rthplace (State or Foreign country) Maryland
	aryland show	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
	the Ma	ecto	Maryland Anne Ar	undel	Pa	asadena 10f. Zip Code			0g. Citizen of What C	1 ☐ Yes 2 No
	h with	al Dir	7616 Beach Drive				1122	. "	U.S.A	•
	deal	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the m 27 is marked other than "natural; or tlems 23a or 28a-f show or other traumatic event, the Macilcal Exertinal must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗖 No		nican, etc.)	Black, Whi	
5-0	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	dent's Usual Occu	pation during most of work ad)	ing	16b. Kind of Business	s/Industry
21215-0036	iene. iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	iire.	Managei			Credi	t Union
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Maryland	Ment Ment Ment Ment Ment Ment Ment Ment	10	John Smit					Sanford		
	d 2 sh th and th r m 17 is m traum		19a. Informant's Name/Relationship (Ty) Ella G. Cotham	oe, Print) (Sister)	1				City or Town, State, aryland 21	
	tem 27		20a. Method of Disposition			sition (Name of matory or other pla			20c. Location - City or	
E	Pages nent of I int: If it	,	1 ☐ Burial 2 【Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State		rematory or other piz	1	·2004 F	Baltimore,	Marvland
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service Lines		/ /22	Name and Addr	ess of Facility	-374	ome P.A. na, Maryla	
\$			23a. Bert 1. Enter the disease, or compli- shock, or heart failure. List only on	cations that aused the dea	th. Do not ent	er the mode of dy	ng, such as cardiac	Pasager or respiratory arre	na, Maryia est.	Approximate
	Physician		Implediate Cause (Final disease or condition	SEPS						Interval Between Onset and Death
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760,	be exe	cal Ex	resulting in death) Last	Due to (or as a consec	quence of):					
687	fficate g phys	edlc	0							L. 03-2
Вох	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medl	in the past 12 months?	3c. If yes, outcome of pregn. 1□Live birth 2□Feta 4□Pregnant at time of c	al death 3 ☐	Ectopic pregnance Other (specify)	у		23d. Date of de Month	livery Day Year
P.O.	at the de by the a tached	hysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown						
ŝ	res that igned to be det		Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause gr	ven in Part I.		acco use contribute to	
Sorc	w require been sig should b	eted	СПІСОТОГ	700 700			-	-		robably 4 Unknown
of Vital Records,	The lav	Completed by						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
tal		Be C	25. Was case referred to medical				26. Place of Death		PNo 1 ☐ Yes	28 No
<u>></u>		To B	examiner? 1 ☐ Yes 2 ☑ No H	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ott			nce 6 □Other (Spe	cifu)
n 0	ding Phys h. After this funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inju		28d. Describe how		
Siol	tendir eath. or: Al	catic	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No			
Division	tel or Attenos after deatles I Director:	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying Phys	ician: To the best of my knows: On the basis of examinations and manner stated.	owledge, death ation and/or in	occurred at the tivestigation, in my	me, date and place, a opinion, death occurr	and due to the car ed at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		MM	29c. Licens			d. Date signed (Mont	
7	-	-) /							17,2004
	10		30. Name and address of person who co	mpleted cause of death (Iter	п 23a) (Туре, RUND E	Print) +10.	SPITAL.	MD 2	1061.	
	Sta Registr		31. Date filed (Month, Day, Year)	/32. Registrar's Signa	ature	words				

			1 - For State Registrar			d / Depa		Health and	Mental Hygi	_) L	25789
П	Physic	an.	1. Decedent's Name (First, Middle, Last,						2. Date of Death		Year	3. Time of Death
	/Medi		Josephine C		Clarl	k			Month 8	13 ^{Day}	04	3:30PM™
	Examir	er	4a. Facility Name (If not institution, give					or Location of De			y of Death	
			Future Care -					llstow		N/		
	Funeral Director		5. Social Security Number $248-26-1140$ 6. Security Number $248-26-1140$	37-	95	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Mi		Year)	9. Birthp Coyr Sumt	place (State or Foreign otry) er Co, S. (
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	Mar Mar	tor	Md. N/A		Ва	altim	ore					1 X Yes 2 □ No
	or 28	Oire	10e. Street and Number		-		10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	ath w	ral	2122 Mt. Holly	St.			2121	6		USA		
	er de Items	Funeral Director		12. Was Decedent Armed Forces?	?	5. 13. V	Vas Decedent of F Yes, specify Cub	lispanic Origin? an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		ce - Americ	
36	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	1	☐ Yes 🛣 No	Specify:		Specii	fy: B	lack
Š	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28e-1 show to Medical Examiner mat be nettling at		15. Decedent's Edu	cation		16a. Deced	lent's Usual Occur	pation	1	6b. Kind of B	lusiness/Inc	dustry
215	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	(Give life. L	kind of work done OO NOT use retire	during most of w d)	rorking			,
21	TO 150 10 10 10 10 10 10 10 10 10 10 10 10 10	Completed	12		,		Homema	ker		Hom	.e	
nd	be filler ital Hyg id other event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle, M	aiden Sumar	ne)	
₹	should be nd Menta marked metic ev	²	Samuel H. Shar						e Walker			
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked any injury or other treumetic ev once.		19a. Informant's Name/Relationship (Ty						Rural Route Number,			
ė, L	1 and Healt em 2		Elizabeth Power 20a. Method of Disposition	ell (D)	20b. Pla		WOOdga sition (Name of	te Ct,	Baltimor	e, Mar		
nor	ages ont of t: If it		1X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cei	metery, cren	natory or other plac	· 1	11.			
Baltimore,	artme orten injur		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	90	Cre	22	awn Mem	ss of Facility				ville,Md.
B	permi Depa Impo any ir		Lloyd M. Est			Ę:	step_Br	others	Funeral ce,Baltin	Ser,	P.A.	21217
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	d the death.	Do not ente	er the mode of dyir	ng, such as cardi	ac or respiratory arres	nore, st,	wu.	Approximate Interval Between
8760,	/Medical Examiner bhysician and bhysician and the prinial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Desease or impry that initiated events resulting in death) Last	Due to (or as Due to (or as	a conseque	ence of):						Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Medl	in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal of time of dea	death 3□ ath 5□	Ectopic pregnancy Other <i>(specify)</i>			1	te of delive	ry Day Year
ecords, l	w requires that been signed should be de	by	Part II. Other significant conditions con	tributing to death b	ut not result	ting in the un	derlying cause giv	en in Part I.		cco use cont		e cause of death? ably X\tag{Vnknown}
\mathbf{x}	Physicien: The law requiths certificate has been ral director, page 2 should	Completed	05.11						24a. Was an autopsy performs 1 \(\text{Yes} \) 2		prior to com death?	osy findings available apletion of cause of XNo
Vital	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 □ Yes ② No	ospital: 1 ☐ Inpatie	20 5	R/Outpatient	2CI DOA Oth		eath (Check only one)		17.1	-
ion of	ding h. After funer	\vdash	27. Manner of Death 1 Natural 2 Accident investigation	28a. Date of Inju (Month, Day	ry 2	28b. Time of Injury	28c. Injun World	y at	Home 5 Residence)
Division	or Oir in t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At hom c. (Specify)	ne, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Numb State)	er or Rural	Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phys (Check only one) 1 Certifying Phys 2 Medical Examir	ician: To the best of er: On the basis of and manner sta	f examinatio	ledge, death on and/or inv	occurred at the tin	ne, date and plac pinion, death occ	e, and due to the cau urred at the time, date	se(s) and ma	nner as sta and due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	mo .	1		29c. License	e number	290	. Date signed	(Month, E	Pay, Year)
			1 V Kew	- JAL	!		D37	333	8	3-16-0	04	
	7		30. Name and address of person who con				-	37	D			04455
									Kandalls	stown	Md.	21133
Chaiyanna Ravi M.D.8620 Liberty Plaza Mall, Randalls: State Registrar AUG 1 8 2004 Chaiyanna Ravi M.D.8620 Liberty Plaza Mall, Randalls: Augustus August												

			1 - For State Registrar	State of M	laryland /	-	artmen tificate			and M	F	leg. Ne	2004	25790
	Physic /Medi		1. Decedent's Name (First, Middle, Last BEVERLY B. CH	•							2. Date of Dea Month August	1 ^{Day}	Ž864	3. Time of Death 7:15 P M
	Examir	ner	4a. Facility Name (If not institution, give Hart Heritage Est 5. Social Security Number 6. Se	ates) ge (In yrs. last	birthday)		tree	Location of the Location of th		8. Date of Birt		County of Death Harford	and (State of Foreign
	Funeral Director		115-20-7954 1D Usual Residence of Decedent	^{□ M 2} 1 X F 8	9	Yrs.	Months	Days	Hours		10/11/1	914	F1	ace (State or Foreigr orida
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It and Mental Hyglene. ?? Is marked other then "natural", or items 23e or 28e-f show traumatic event, its Medical Exerciper from the colling at	ector	MD Harford 10e. Street and Number	3	10c. City, To	own or Lo Be1	Air	0.1-						0d. Inside City Limits 1 1 1 Yes 2 □ No
	ter death with itams 23a or iter must be r	Funeral Director	201 F. Crocker I	12. Was Decedent	Ever in U.S.	13. \	10f. Zip	21	.014 spanic Ori	gi <u>n</u> ? (Spe	ecify Yes or No- Rican, etc.)		USA 4. Race - America	
9003	hours after ural, or ita	b	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	Armed Forces' 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	1	I□Yes 2	. No	Specify:	, Puerto	Rican, etc.)		Black, White, e	e
Baltimore, Maryland 21215-0036	d within 72 giene. ir than "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12			(Give life. L	lent's Usua kind of wor DO NOT us arian	k done d e retired)	tion <i>uring</i> mosi	of work	ing	16b. Kin	d of Business/Indi	
yland	should be filed ind Mental Hygi is markad othar umatic avant, I	To Be C	17. Father's Name (First, Middle, Last) Roy E. Bodet								e (First, Middle, eahen	Maiden S	Sumame)	
e, Mar	s 1 and 2 sho if Health and item 27 is ma other traums		19a. Informant's Name/Relationship (T) Carole Ann Chase/I			201 F	Croc	ker		e, B	el Air,	MD	Town, State, Zip (
ltimor	Page nent c ant: If ary or		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signal 19 ■ Funeral Service □ Cans		1 00000	tery, cren e Cre	matory or ot	her place Y		8/13	/2004		ation - City or Tow	vn, State
Ba	permit. Departr Imports any inji		23a, Part1. Excelline disease, or compl	Vovel	d the death D	Н		Fune	ral Ho	me,Ir			t.,Delta, B	PA 17314 Approximate
	Pnysician /Medical		mock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each i	ine.	0	oran			rter		sen		Interval Between Onset and Death
	death certificate be executed x death certificate be extending physician and death of for use as the burial-transit and the control of the certification of	cal Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequenc	ce of):								
j.	that the death certifical led by the attending phy detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		Ectopic pre Other (spe					23	3d. Date of delivery Month D	y Day Year
rds, P	equires en sigr	þ	Part II. Other significant conditions con	ntributing to death b	out not resulting	in the un	derlying ca	use giver	n in Part I.		23e. Did tol		e contribute to the	cause of death?
	The law ate has b	Completed									24a. Was a autops perform	у	24b. Were autops prior to comp death?	sy findings available pletion of cause of
ION OT VIE	Attending Physician: The death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 Vo 27. Manner of Death 1 Accident investigation	lospital: 1 ☐ Inpatii 28a. Date of Inju (Month, Da	ent 2 ER/0 ury 28b	Outpatient Time of Injury		c. Injury	4 🗆 Nur	sing Hor	Check on on	ince 5	ther (Specify)	CARL
DIVISION	tal or Attendi s after death. al Director: A ad in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At home, tc. (Specify)	farm, stre	et, factory,	office		2	28f. Location (St City or Town	reet and n, State)	Number or Rural I	Route Number,
	To tha Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examinates	sician: To the best ner: On the basis o and manner st	if examination a	ge, death and/or inv	estigation,	n my opi	nion, deat	l place, a	and due to the ca	use(s) a ate and p	nd manner as stat lace, and due to the	ted. he cause(s)
•	with To Corr	×	29b. Signature and title of certifier	MP			7	39	889			Dus	signed (Month, Da	
4)			empleted cause of c	death (Item 23a	(Type, F	Print) ACPL	Ail	Ru	(D.	~ 40	2	OM	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registr	ar's Signature	9	por	1						

			For State Registrar	State of M	laryland	•	artment <i>tificate</i>					giene	004	25791
	Dhusia		1. Decedent's Name (First, Middle), Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medi		Helen	(Э.			lley			August	16	2004	9:00P M
4	Examir		4a. Facility Name (If not institution	, give street and number)		4b. City, 1	Town, or	Location of	of Death	Ü	4c.	County of Dea	th
			1520 Philadel					орра					Harfor	
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birti (Month, Day	h /, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		181-40-2568 Usual Residence of Decedent	- A	95	113.					March 3	19:	L9 Ne	w York
	land		10a. State 10b. County		10c. City, T	Town or Lo	cation							10d. Inside City Limits
	A sh	ō	Maryland Harfo	rd	Jop	ра								1 ☐ Yes 2 ☑ No
	28a	Je C	10e. Street and Number				10f. Zip	Code				10g. Citiz	zen of What Co	ountry?
	3a o	by Funeral Director	1520 Philadel	nhia Poad			2	1085					TT C A	
	ma 2	Jera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \				gin? (Spe	cify Yes or No- Rican, etc.)	. 1	U.S.A. 14. Race - Ame	
9	after or ita	Œ	1 ☐ Never Married 2 ☐ Marri	ied Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	No		_			i, Puerto i	Hican, etc.)		Black, Whit	e, etc.
03	raf',	l by	3 Widowed 4 □ Divorced	Year or Dates:			I∐ Yes 2	KT 140	Specify:				Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or itama 23a or 28a-f show its Madical Examinar crust be notified at	Completed	15. Decedent (Specify only highes		1	6a. Deced (Give	lent's Usual kind of worl DO NOT use	Occupa k done d	ation <i>Juring mos</i>	t of worki	ng .	16b. Kir	nd of Business	/Industry
12	within lene. then	Id m	Elementary/Secondary (0-12)	College (1-4or	5+)									
	be filed within 72 hours after death with the Marylan nai Hygiene. Id other then "natural", or itama 23a or 28a-1 show avent, the Medical Examilizat must be publised at		17. Father's Name (First, Middle,	(201)		Adm	inist	rati		ria Nama	(First, Middle,		lospita	1
anc	2 should be filed within and Mental Hygiene. Ia markad other than aumatic avant, Ite M	Be	Joseph	_as()	Do	ptula					(FITS), MIGGIE.	waiden :		
ž	should nd Men marka umatic	٩	·	hip (Tuno Brint)				(Street m		se	/ Courte Museum	- City		ytek
Maryland	d 2 sho	1	19a. Informant's Name/Relations			ame					l Route Numbe			
	ges 1 and 2 should t of Health and Mer if itam 27 ia marka or othar traumatic		Cynthia Colley 20a, Method of Disposition	(Daughter Ir	11 aw) 20b. Place	7447 e of Dispo	Biscs sition (Nam	yne e of	Eav	Blvd	. Middl		ver, M.	3. 21220 Town State
Baltimore,			1 ☑ Burial 2 ☐ Cremation		ceme	etery, cren	natory or oti	her place	9)	Augu	st 18,		200	
臣	그 든 뿐 등 .		 4 □ Donation 5 □ Other (S_i 21. Signature of Fun and Service 		Uak	Lawr		1 Addron	e of Encilit	.,				, Maryland
Ba	Depa Impo any i		21. Signature of day and Sewice	1	: 1	1	V. Dat	row	ski-C	hojn	acki Fu	nera	1 Home:	s P.A.
			23a. Part 1. Enter the disease, or	complications that cause	of the death I	Do not ente	LOO5 I	ound.	alk A	ve.	Baltimo	re,	Maryla	nd 21224 Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.	DO HOL BILL	D	7 i	, such as	P	i lespilatory an	0 51,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	ncer		K	TV	•	Ju	ng			months
	Examiner			Due to (or as	s a consequen	nce of):					0			
		Į.	Sequentially list conditions,	b. Due to for as	s a consequen	ice of					_	-		
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury											
	be executed sician and burial-transit	xa	that initiated events resulting in death) Last	c. Due to (or as	s a consequen	ice of):								
8760,	Attanding Phyaician: The law requires that the death certificate be executed refeath. refeath. ector: After this certificate has been signed by the attending physician and better the funeral director, page 2 should be detached for use as the burial-transit.			d										
89	ficate physics the	Physician/Medical		0.										
Box	death certifica s attending ph d for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								2	3d. Date of del	iverv
ă	death a atte	clai	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pre Other <i>(spe</i>						Month	Day Year
P.O.	it the di by the tached	hys	9 Unknown	9□ Unknown										
σ.	res that signed b	by PI	Part II. Other significant condition	ns contributing to death I	but not resultin	ng in the ur	nderlying ca	use give	n in Part J.		23e. Did to	bacco us	se contribute to	the cause of death?
rds	n sig	D D									1 □ Y	es 2	No 3□Pr	obabły 4 Unknown
00	w requir s been si should	Completed									24a. Was a	ın	24b. Were au	topsy findings available
Re	he lay e has age 2	Ĕ									autops perfor	med?	prior to death?	completion of cause of
of Vital Records,	yaician: The is certificate hi director, page	0	25. Was case referred to medical						26 Place	of Doath	1 ☐ Yes (Check only or		1 🗆 Yes	2 □ No
5	yaicia is cert direct	To B	examiner? 1 ☐ Yes 2 ☆ No	Hospital: 1 ☐ Inpati	ient 2□ER	/Outpatien	3 DO	Othe			ne 5 ☑ Resid		Other (See	-14-1
of	g Phy ler this neral c		27. Manner of Death	28a. Date of Inju		b. Time of	_	c. Injury Work			8d. Describe h			aiy)
ion	nding I ith. :: After e funer	atlo	1 Natural 5 Pending 2 Accident investig	9	ay Year)	injury	м		:7 ′es 2 🔲 !	No				
Division	Attandi er death. rector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of In	jury - At home	, farm, stre	et, factory,	office		2	8f. Location (S	treet and	Number or Ru	ral Route Number,
Ö		Certification;	4 Homicide	building, e	tc. (Specify)						City or Tow	n, State)		
	To the Hospital or Attan within 24 hours after deat To tha Funaral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physicien: To the best	of my knowle	dge, death	occurred a	t the tim	e, date an	d place, a	nd due to the c	ause(s) a	and manner as	stated.
	n 24 n 24 na Fu	edical	(Check only 2 Medicel I one)	Exeminer: On the basis of and manner si	of examination	and/or inv	estigation,	in my op	inion, deat	th occurre	d at the time, d	ate and p	place, and due	to the cause(s)
	To the Howithin 24 To the Forcemplete	ž	29b. Signature and title of certifier	(2)/1 -		-			number		2	9d. Date	signed (Month	4.6
1			•	1 The state of the	10		D	00	566	07	/	typ	ust 1	7th, 2004
			30. Name and address of person	who completed cause of	death (Item 23	Ba) (Type, i	Print)							
			JOSEPH ANG	ELO, Sale	#10	6. (002	_<	ATu	1000	Rd C	BEL	A ER,	MD 21014.
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	₽	1							
	Regist	rar	AUG 1 8 200	4 Gentre	U 19	1	back	2						

			For State	State o	of Marylar						_	0.01	05.300
				e, Last)		001	tinoate or	Dealin			- Gara	UUL.	3. Time of Death
			Mary		sther		Dyes			Month August	Day 15	2004	0712 ^M
			•	-			4b. City, Town, o	r Location	of Death				
		Decederate Name (Prist, Middle, Last) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Last) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Prist, Middle, Marten Name) Decederate Name (Pr											
	Funeral Director		579-12-5697						Min.	(Month, Day	, Year)	Cou	place (State or Foreign ntry) Land
	and				10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be rediffed at	to	MD Queen	Annes	Si	tevensv	rille						1 ☐ Yes XXNo
	r 28a	Certificate of Death Certificate of Death		ntry?									
	23a c	1- Size 1- December Number First, Middle, Last) 1- December Number First, Middle, Last) 1- December Number First, Middle, Last) 1- December Number First, Middle, Last) 1- December Number First, Middle, Last) 1- December Number First, Middle, Last) 1- December Number First, Middle, Last) 1- December Number											
9	s after dea , or items animer m		1 Never Married 2X Marr	ried 1 ☐ Yes If Yes, Gi	orces? 2 📉 No ve		f Yes, specify Cuba	an, Mexicar	gin? (Spec n, Puerto Ri	ify Yes or No- ican, etc.)		Black, White,	etc.
200	tural	1- Supplementary Name (First, Modelle, Last) 1- Decederary Name (First,											
0	hin 72 n "ng Medik	The second of the second secon											
7	ed wit	Com	12			Home	maker						ne
alla	be filk tat Hy ad oth event	Be		•					•			•	
Z	hould d Mer marke maric	Jo				19h Mailin	Address (Street						Code)
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ก	s 1 ar f Hea item other		20a. Method of Disposition		20b. I	Place of Dispo	sition (Name of	1					
Ē	Page nent o int: If				State	-	-		8/19/2	2004	Loth	ian. MD	
Daltimor	permit. Departn Imports any inju		21. Signature of Funeral Service	4:0:00	1	22	Name and Addre Hardesty	ss of Facility Fund	eral I	Home P.	A.	. MD 21	40)
	100		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deal	th. Do not ente						, 110 21	Approximate Interval Between
F	Physician		Immediate Cause (Final disease or condition		Dan	umai	1:0					- 1	Onset and Death
	/Medical Examiner		resulting in death)	Due to		-	· · · · · · · · · · · · · · · · · · ·					-	
		_	Sequentially list conditions,	b. Tunto	Fron	IC 6	nenal		1250	FFICI	enc	2007	
	nted insit	nlne	Cause (Disease or injury		00	0 11	A						
2	exection and ital-tra	Exai	resulting in death) Last	C. Due to	(or as a consec	ruence of):	<i>/</i>						
00/0	cate be executed physician and the burial-transit	cal		d	CH	F							
		Med	IF FEMALE:										
XOO .	death certifi e attending ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live t	birth 2 Feta	al death 3					230		ory Day Year
5	the de	iyslc	1 □ Yes 2/1\No 9 □ Unknown			10atri 5_	Other (specify)						
r.	The law requires that the ate has been signed by th page 2 should be detache		Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the ur	nderlying cause giv	en in Part I.		23e. Did tol	oacco use	contribute to th	ne cause of death?
Ď.	quire an sig uld be		-							1 □ Y€	s 2121	vo 3 ☐ Prob	ably 4 Unknown
	law re	plet									n 2	4b. Were auto	psy findings available mpletion of cause of
ב ק	The ate ha	Com								perform	ned?	death?	•
= =	cian: ertific ector,	a				,	701		of Death (Check only on	e)		
5	Phyei this c	-		- 10			3 DOA	4 LI Nu					y)
200	ding h. After funer	tlon	1 Matural 5 ☐ Pendir	ig (Mon	th, Day Year)					d. Describe no	W IIIIuiy O	ccurred	
<u> </u>	Atten or deal ector. by the	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At h	ome, farm, stre	eet, factory, office		28	f. Location (St	reet and N	lumber or Rura	l Route Number,
5	ital or rs afte al Dir ed in	Cert	4 - Homedo	Build	ing, etc. (<i>Speci</i> i	· · · · · · · · · · · · · · · · · · ·			ļ	City of Town	r, State)		
:	n 24 hou n 24 hou he Funer	edical	(Uneck only 2 Medical	Examiner: On the b	asis of examina	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date an pinion, dea	d place, and th occurred	d due to the ca at the time, da	ause(s) and ate and pla	d manner as st ace, and due to	ated. the cause(s)
1	To the To the Comp	Σ	29b. Signature and title of chitifie	7				_	7	_ 2	9d. Date s	igned (Month,	Day, Year)
			· Y						~~		8/1	6/07	/
1)		30. Name and address of person		·	m 23a) (Type, I	210 8	Die	tene	to 7)r. C	Thest	er mb
:-					Registrar's Signa	ature &	Spor	h					28619

			1 - For State Registrar	State of I	Marylar		artmen rtificate				lental Hyg	iene	<u> </u>	25793
	Physic		1. Decedent's Name (First, Middle	a, Last)							2. Date of Death	21.00	V	3. Time of Death
	/Medi		Charles	U.			Dayh	off			August		2004	3:45 p M
	Exami	ner	4a. Facility Name (If not institution				1		Location of	of Death		4c. County	of Death	
	F		Crofton Conva 5. Social Security Number			last birthday)	If Under	Crof	ton	24 Hrs	9 Date of Birth	Anne	e Aru	
	Funeral Director		214-16-9223 Usual Residence of Decedent	1 X DXM 2□ F	83		Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Oct. 24	, 1920	9. Birthp Coun Mar	lace (State or Foreign try) yland
	nyland how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10	0d. Inside City Limits
	Ba-1 s	Director		Arundel	A	nnapo1	is							XXYes 2 □ No
	with th	Dire	10e. Street and Number				10f. Zip				10	g. Citizen of V	What Coun	try?
	a 23	era	866 Rudder Way		nt Consin II	C 40.3		2140				USA		
36	within 72 hours after death with the Maryland ane. than "natural", or itema 23a or 28a-1 show ha Medical Examiner must be retified at	by Funeral	1 Never Married 2 Marr 3XXWidowed 4 Divorced	ied 12. Was Decede Armed Force iy Yes 2[If Yes, Give Year or Date	es? □ No		was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
Maryland 21215-0036	2 hou	Completed	15. Decedent	's Education		16a. Deced	ient's Usua	1 Occupa	tion		11	6b. Kind of Bu		
215	thin 7	nple	(Specify only highes Elementary/Secondary (0-12)	College (1-4c	or 5+)	(Give	kind of wor DO NOT us	k done d e retired)	uring most	of worki	ing			
21	e filed wi Il Hygien other th vent, the			4		Engin	eer							ratories
and		Be	17. Father's Name (First, Middle,								(First, Middle, M		ne)	
Š	2 should be and Mental Is marked o	은	Charles William 19a. Informant's Name/Relationsl			40h 14-115-		101			h May Ur			
Ma	nd 2 s lith an 27 is i		Sharon Ackerma		- \						I Route Number,			
d)	s 1 and 2 f Health Item 27 other tra		20a. Method of Disposition		20b. P	lace of Disposemetery, cren	Sition (Nam	ad Ki	un Dr		Sterlir	Oc. Location -		
JOE L	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Removal from Star		emetery, cren tro Cre				16			•	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service		He		Name and	Address	of Facility	,		Baltimo	re, M	ID
ä	Depa Impo any i		Phalala S	Truck	Int		Hard	esty	Fune	ral	Home P.A.	l. lic M	m 21/	.01
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the death	Do not ente	er the mode	of dying	, such as o	cardiac o	r respiratory arres	тто и		Approximate Interval Between
H	Physician		Immediate Cause (Final disease or condition	S		um ou	es C	oll	1 C	-1	aft	Jead +1	M.K	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ		<u>در د</u>			ш	0.1	jeau v		agears
	Examiner	_	Sequentially list conditions,	ъ										
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequ	uence of):								
	xecut and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or a	as a consequ	uence of)-								
8760,	cate be executed ohysician and the burial-transit					-51.05 51,1								
687		edic		d										
Вох	that the death certific led by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d. Date	of deliven	v
	death	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant	at time of de		Ectopic pre Other (spe					Mon		Day Year
P. O.	at the by the	hys	9 🗆 Unknown	9□ Unknown										
Ś	8 76 8	by	Part II. Other significant condition	as contributing to death	but not resu	ılting in the un	derlying ca	use giver	n in Part I.		T			cause of death?
ord	w require	ted			-	_					1 🗆 Yes	2 DHO	3 ☐ Probal	bly 4 □Unknown
Record	e 2 sh	Completed									24a. Was an autopsy	l pi	ere autops	sy findings available pletion of cause of
											performe 1 Yes 2 □	d? de	eath? □ Yes 2	
Vital	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:						of Death	(Check only one)			
	Phys r this ral di	. To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpai		ER/Outpatient 28b. Time of			4 Librars		ne 5 Residenc			
o	ding th. Afte fune	tlor	1 Natural 5 Pending 2 Accident investig	(Month, D	Day Year)	Injury	M	c. Injury a Work? 1 □ Ye	s 2 □ N		8d. Describe how	injury occurre	Ø	
Division of	al or Attending Physician: after death. I Director: After this certific d in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of I	njury - At ho	me, farm, stre				-	8f. Location (Stree	et and Numbe	r or Rural I	Route Number
	s afte	Sert	4 Homicide determine	building, e	etc. (Specify)					City or Town, S	State)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Hospital 24 hours a Funeral I rely filled		29a. Certifying	Physician: To the bes	st of my know	vledge, death	occurred at	t the time	, date and	place, a	nd due to the caus	se(s) and man	ner as stat	ed.
	To the Hospital or A within 24 hours after To the Funeral Dire. completely filled in by	Aedical	one)	xaminer: On the basis and manner s	or examinat	ion and/or inv	estigation, i	n my opir	nion, death	occurre	d at the time, date	and place, ar	nd due to th	ne cause(s)
	vit vit	Σ	29b. Signature and title of certifier	00				License r				Date signed	/	
7			Hones ICh	es				13	58	18		y 116	104	1
•	0		30 Name an address of person w	no co d cause of	death (Item	23a) (Type, P	つ	N.	6	7	nbn; lls	641	1201	
	Sta	e	31. Date filed (Month, Day, Year)	32. Tegis	trar's Signat	ure /	un se	HL	7 0	an	n Prijis	ל נותי	1037	
	Registr		AUG 1 8 2	/.	we	19	don	Ks						

			1 - For State of Registrar	Maryland / Depa	artment of Heali		al Hygiene	101. 25791.
	Physici /Medio		1. Decedent's Name (First, Middle, Last)	emski			te of Death onth Day	3. Time of Death 2094 M
	Examir Funeral	ier	4a. Facility Name (If not institution, give street and number S. Social Security Number 6. Sex 7	QNC. Age (In yrs. last birthday)	4b. City, Town, or Loca If Under 1 Year If Under 1 Months Days Hor	ille	te of Birth onth, Day, Year)	9. Birthplace (State or Foreign
	Director Mount	ľ	215-48-3060 1□M 22€F Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo		Dis Mill. De		1 Baltimore, MD
	death with the Maryland ims 23e or 28a-f show r.must be rotified at	I Directo	10e. Street and Number 8712 Maravoss 2	ane	10f. Zip Code	34	10g. Citizen	of What Country?
2-0036	after or Ite	by Funeral Director	11. Marital Status 11. Marital Status 12. Was Deced Armed Force 1	es? No	Was Decedent of Hispanion of H	c Origin? (Specify Yexican, Puerto Rican, ecify:		Race - American Indian, Black, White, etc. ecify: Why te
21215-0	within 72 he ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired	most of working	16b. Kind o	of Business/Industry
Maryland	2 should be filed and Mental Hygid is marked other eumetic event, II	To Be (17. Father's Name (First, Middle, Last) Stanley Pau 19a, Informant's Name/Belationship (Type, Print)	emski acen 196 Mailir	18. N	Mother's Name (First,	Elizas	beth Krac
	s 1 and f Health item 27 other tr		Stanley + Amelia Demsk 20a. Method of Disposition Burial 2 Cremation 3 Removal from St	20b. Place of Dispo	2 Marara	/	20c Location	Alle, MD, 21234
Baltimore	permit. Pages Department of I Importent: If it any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lips see	HOLY KO	SASY COM. Name and Address of E	Hug. 18,2	SETTO CIE	Tem) 21720
	Physician /Medical Examiner	ner	Sequentially list conditions, b	in line.	er the mode of dying, such	h as cardiac or respir	atory arrest,	Approximate Interval Between Conset and Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical Examiner	that initiated events	as a consequence of);				
O. Box 6	that the death certifica hed by the attending ph detached for use as th	Physician/Medical		n 2 ☐ Fetal death 3 ☐ It at time of death 5 ☐	Ectopic pregnancy Other (specify)			Date of delivery Month Day Year
rds, P.O	w requires that i been signed by should be deta	by	Part II. Other significant conditions contributing to deal Down's syndeme Seitare chisorder	th but not resulting in the ur	nderlying cause given in P	art I. 236	e. Did tobacco use c	ontribute to the cause of death?
of Vital Records,	(U LL	Completed					a. Was an 24 autopsy performed?	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vit	Phy this	Certification: To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	atient 2 ER/Outpatien Injury Day Year) 28b. Time of Injury Injury - At home, farm, stre	Other: 4 DOA 28c. Injury at Work? M 1 Yes 2	28d. De:	Residence 6 🗆 C	
Οį	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier ** **Z.Certifying Physician: To the be	, etc. (Specify)	Occurred at the time, date	City	to the cause(s) and	manner as stated
•	To the Hi within 24 To the Fu completely	Medical	29b. Signature and title of certifier	s of examination and/or inv	estigation, in my opinion, 29c. License numb	death occurred at the	e time, date and plac 29d. Date sig	e, and due to the cause(s) ned (Month, Day, Year) - \$7 16, 2054
7)							,00 21209
DHI	Sta Registr	ar		istrar's Signature				

ORIGINAL

			1 - For State Registrar	State of Maryla	and / Depa			Mental Hy	-	004	25799
	Physic /Medi		Decedent's Name (First, Middle, Last GENEVIEVE A.					2. Date of De Month AUGUS	Day	2004	3. Time of Death 1:50 P
	Exami		4a. Facility Name (If not institution, give PARADISE ASSISTED				or Location of Deat	h	4c. Coun	ity of Death	
	Funeral Director		5. Social Security Number 6. Se 212-01-2500 1C]M 2(3√F	rs. last birthday) OO Yrs.	If Under 1 Yea Months Days		8. Date of Birt (Month, Da 8/11/	th y, Year)		lace (State or Foreign stry)
	ith the Marylan or 28a-f show	Director	10a. State 10b. County MD BALTIMOF 10e. Street and Number	₹E	CATC	NSVILLE 10f. Zip Code			10g. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 🛣 No
036	be filed within 72 hours after death with the Maryland tal Hygiene. Ad other then "naturel", or Items 23a or 28a-1 show event, the Modical Exerting the truitled at	by Funeral Director	6000 CHESWORTH RC 11. Marital Status 1 Wever Married 2 Married 3 Widowed 4 Divorced	DAD 12. Was Decedent Ever in Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:			228 Hispanic Origin? (Sban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA 14. Ra Bla Spec	ace - Americ ack, White, o	etc.
21215-0036	c * 3	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occu kind of work don DO NOT use retir	during most of wor	rking	16b. Kind of I	Business/Ind	dustry
Maryland 2	should be filed within and Mental Hygiene. I marked other then umatic event, the M	To Be Co	12TH GRADE 17. Father's Name (First, Middle, Last) JUDSON DEY			BOOKKEEP	18. Mother's Nar	ne (First, Middle, NA C. WH	Maiden Suma ITE	me)	RAL HOME
	1 and 2 s Health ar em 27 ls ther trau		19a. Informant's Name/Relationship (Ty ELIZABETH DEY 20a. Method of Disposition	NIECE		CHESWOR	t and Number or Ru TH ROAD	ral Route Numbe CATONSVI Date		212	28
Baltimore,	permit. Pages Department of I Importent: If its eny injury or o		1 ½ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	ALTIMORE	CEMETE Name and Addr	RY 8/2	0/2004 E JOHNSC	BALTIN N FUNE	MORE, RAL HO	MD DME, P.A.
ļ	Physician /Medical Examiner	Iner	if any, leading to immediate cause. Enter Underlying	ications that caused the dene cause on each line. a. RESPIRATO Due to (or as a const Due	eath. Do not entropy Frequence of):	er the mode of dy	ing, such as cardiac	or respiratory are	rest,		Approximate Interval Between Onset and Death
x 68760,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons							
.O. Box	it the death c by the attend tached for us	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	3c. If yes, outcome of pred 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3 [Ectopic pregnand Other (specify)	ey			ate of deliver onth [y Day Year
ecords, P.	w requires tha been signed I should be det	by	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the ur	derlying cause gi	ven in Part I.				e cause of death?
ř	The The ate hg	Completed						24a. Was a autops perform	med?	prior to com death?	sy findings available ipletion of cause of
	ding Physici n. After this cer funeral direc	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manno of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing H	th (Check only on ome 5 TReside 28d. Describe ho	ence 6 Pot		Cessester Civing
5	itel or Attendi irs after death. rel Director: A led in by the fu	Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe				28f. Location (St City or Town	n, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only only) 29b. Signature and title of certifier	sician: To the best of my k ner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my	opinion, death occur	red at the time, d	ate and place,	and due to t	the cause(s)
(To To		30. Name and address of person who co	allager,	, Mo	29c. Licen:	1 4 8 C	A	9d. Date signe	7, 2	004 004
	Sta	te		impleted cause of death (it	ern zda) (Type, I 7 16 M Inature Z	aiden	Choice	Lane	Bacro	mi	91778
	Registi		HUG I & CL	JU4 June	P	spa	Ks				

State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per Verb, G836 1,0/196/94dhibpeath 2. Date of Death 1 Decedent's Name (First Middle Last) Month **Physician** 9:20 P M Helen Doreatha Eldridge 16,2004 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Montgomery 31 Beaumont Rd SilverSpring 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Min. Months Hours 1□ M 27 F 79 Sept.4,1924 217-26-8046 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show the Medical Examiner Hast be notified at 1 ☐ Yes 2X No Director MD Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō Items 23a 7741 Freetown Road 21060 U.S.A. deeth Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peges 1 and 2 should be filed within 72 hours after or nen of Health and Mental Hygiene. ant: if item 27 is marked other then "natural", or iter ury or other traumatic avent, the Modical Esterines. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Black 3 ◯Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Federal Gov't Elementary/Secondary (0-12) Coltege (1-4or 5+) Ft. Meade DentalCL. 12 Dental Hygienist Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Be Elsie Curry Mickie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marsha Henderson(daughter) 7743 Freetown Rd. Glen Burnie MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) permit. Pege Department of Important: If any injury or once. Cedar Hill 21Aug2004 Brooklyn MDEstep Bros. Funeral Serv. P.A. 1300 Eutaw Place Balto. MD 21217 21. Signature of Funeral Service Licensee E.N.Walker Jr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ancer Months Pnysician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner that initiated events resulting in death) Last and Due to (or as a consequence of) burial-t P.O. Box 68760. as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2[] No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 there is Home ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Mann Certification: 1 atural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide hours after To the Hospitel within 24 hours a 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D39505 Hospital Dr. Glen Burnie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kan 305 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 8 2004 Registrar

			1 - For State Registrar	State o	f Marylan		artment of I		Mental Hygi	ene g. p2.	25707
	Physic	an	Decedent's Name (First, Middle					Dodin	2. Date of Death Month	the same of the sa	3. Time of Death
>	/Medi Examir	cal	4a. Facility Name (If not institution	give street and nur		ANO		or Location of Dea	AUGUST	4c. County of De	1 12 10
			5. Social Security Number	2013R 6. Sex	7 Ann //n	la an himbataul	10WS			BALT	wels
l	Funeral Director		20 20 5027	5.59X 15€M 2□F	7. Age (In yrs.	Yrs.	Months Days	Hours Min	n. (Month, Day,	1936 UE	rthplace (State or Foreign Country)
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	the Mar 28a-f s	Director	Machan Bax	39 aug		PRKL	10f. Zip Code		140	Citizen (IIII)	1 ☐ Yes 2 No
	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-f show ir than "natural", or Itams 23a or 28a-f show ir et martined at the Madical Examitrational to multiled at		2514 BURR		040		ar	7		g. Citizen of What C	
9	after de or Itam	Funeral	11. Marital Status 1 Never Married Married	Armed Fo	2 🗆 No	1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 1 No		Specify Yes or No- irto Rican, etc.)	14. Race - Am Black, Wh	
21215-0036	2 hours atural',	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent	Year or D s Education	ates: W.W		dent's Usual Occup	Specify:	110	Specify: Co	# TE Lindustry
1215	within 7; ene. than "n	Completed	(Specify only highest	grade completed) College (1	I-4or 5+)	(Give life. I	kind of work done OO NOT use retire	during most of w	orking		
2 pt	e file otha vant,	Be Co	17. Father's Name (First, Middle, L	ast)		2	214	18. Mother's Na	ame (First, Middle, Ma	aiden Sumame)	AKZ LO.
Maryland	should be nd Mental r markad c umatic eva	To E	ACOLOJ 19a. Informant's Name/Relationsh		ANOT	40h Maille	Add (Chu)		TEARST	BAKER	- A A A A A A A A A A A A A A A A A A A
	nd 2 salth ar 27 is r trau		Z. I Arzist			4128	BURR	and Number of A	Rural Route Number, (City or lown, State,	ZID CODE) 21234 ARVLAND
áltímore,	Pages 1 a nent of Hea int: If itam iry or otha		20a. Method of Disposition ↑ Burial 2 □ Cremation ↑ 4 □ Donation 5 □ Other (Sp		State 0	emetery, cren	sition (Name of natory or other pla	CO) Au	9. 16 20	c. Location - City o	Town, State
Baltí	permit. Pages Department of Important: If i any injury or once.		21. Ignim 1 Funer Service L	1	100	Rollis	Name and Addre	ess of Facility	1004 F	ر کانگ	21234
	0.D ≥ 6 0		23a. Part1. Enter the disease, or o	emplications that c	aused the death	n. Do not ente	800 HA		COFO HAR	KVILLI	Approximate
	Physician		shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	uach line.	Ca	neer				Interval Between Onset and Death Manual Co.
	/Medical Examiner				or as a consequ	uence of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):		-			
,00	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					
68760,	ificate b g physic as the b	edica		d							
Вох	ath cert attending for use	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	come of pregna	death 3 🗆	Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
P.O.	at the de by the a stached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno			Other (specify)				
	The law requires that the death certificate be executed tie has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	d by	Part II. Other significant condition	Struc	five L	ulting in the un	derlying cause giv	en in Part I.	. ,		the cause of death?
Division of Vital Records,	ne law rec nas beer ge 2 shou	Completed by	ischemic	bstr-c care inelli	io m	yop.	1+kg		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
tal F	ician: The certificate I rector, pag	0	25. Was case referred to medical	inelli	ty	0			performe 1 Yes 2	d? death? No 1 □ Yes	2 □ No
of Vi	Physici this cer al direc	To B	examiner? 1 Yes 2 No 27. Manner of Death		npatient 2 1			er: 4 🗌 Nursing I	Home 5 Residence		city) Laspice
ion	l or Attanding Phys after death. Diractor: After this I in by the funeral di	atlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	ation	h, Day Year)	28b. Time of Injury	28c. Injury Wor M 1	yat k? Yes 2 □ No	28d. Describe how	injury occurred	,
Divis	after de Diracto	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 28e. Place	of Injury - At hong, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the xaminer: On the ba and mann	isis of examinat	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occ	e, and due to the caus arred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	in Ril		0	29c. License	e number	29d.	Date signed (Mont	
,,1	116		30. Name and address of person w		/			5305		90511	
	٧		W. A. Riley 31. Date filed (Month, Day, Year)	GBMC	G70	1 N.	Charles	D lo	elto ma	21209	
	Sta Registr		AUG 1 8	2004	Depende	4	Loan	41			

			1 - For State Registrar	State of Mar	ryland /	-	artment rtificate			and M		Reg. No.	104	25798
	Physici /Medio		1. Decedent's Name (First, Middle, Last	pstein							2. Date of De Month	ath 15	ÖH	9:08 PM
	Examir	er	4a. Facility Name (If not institution, give				An	mag	Location o			An	nty of Death	Frande 1.
	Funeral Director		031 02 7720 .	7. Age	(In yrs. last	Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir NOV - 3 Da	r939	9. Birthp	place (State or Foreign htry) NY
	Aaryland f show	ō	Usual Residence of Decedent 10a. State 10b. County MD ANNE ARU		10c. City, To	own or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-1	Funeral Director	MD ANNE ARU 10e. Street and Number	NDEL		CIOI	10f. Zip					10g. Citizen o	of What Cour	
	eath w	eral	2628 SALFORD DRI	VE 12. Was Decedent Ev	ver in U.S.	13. 1	Was Deced		1114 spanic Ori	gin? (Sp	ecify Yes or No	- 14. R	ace - Americ	USA can Indian.
980	perrit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Plygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, The Medical Examination in must be notified all once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			fYes, spec 1 ☐ Yes 2		n, Mexicar Specify:	, Puerto	ecify Yes or No Rican, etc.)	Spec	lack, White.	
15-0	in 72 ho "natur	oleted	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	dent's Usua kind of wor DO NOT us	k doné d	luring mos	t of work	ing	16b. Kind of	Business/In	dustry
212	ed withi ygiene. her than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+))	COMP	UTER I	ENGI				COMPUT		
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, The Market	To Be	17. Father's Name (First, Middle, Last) DANIEL				TEIN			HEI	e (First, Middle, _EN			MARX
	aith and 2 shaith and 2 shaith and 27 is n		19a. Informant's Name/Relationship (T) LINDA J. EPSTEIN				9	•			al Route Numbe			Code)
ore	Pages 1 and 2 nent of Health int: if item 27 l		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ F	Removal from State			sition (Nam natory or ot				²⁰⁰⁴	20c. Locatio	on - City or To	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licens		KNESS	22	2. Name and	d Addres	s of Facilit	y SOI	LEVIN	SON & E	ROS.,	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the cause on each line	he death. C								ا وحاجاتا.	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acute	Re	spil	ato	M	Dis	fre	es Syr	rd ron	.0	Onset and Death
	Examiner		ſ	Aspira	consequen	of of):	me	m	mi	a,	F6			
	uted 1 Insit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nash	consequen	ce of):	ac?	1 e	200					
,8760,	ate be executed hysician and the burial-transit	ical Exa	that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):			,,,,	*				
9	.0 0.0		IF FEMALE:	22. 16										
P.O. Box	the death certif the attending ched for use a	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal de	ath 3[Ectopic pre Other (spe						Date of delive Month	ery Day Year
	The law requires that the death to has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant conditions co	ntributing to death but	not resultin	g in the u	nderlying ca	use give	en in Part I		23e. Did t			ne cause of death? nably 4 Unknown
Division of Vital Records,	The law requir ate has been s page 2 should	Completed											prior to col death?	psy findings available impletion of cause of
/ital		Be	25. Was case referred to medical examiner?	Hospital:				Otho			h (Check only o	nne)		
of	ding Phya h. After this (funeral dir	n: To	27. Manner of Death	28a. Date of Injury (Month, Day)	28	Outpatier b. Time of Injury		A Durk Bc. Injury Work			ome 5 Resid 28d. Describe I			y)
isior	or Attending Physician: ifler death. Director: After this certific in by the funeral director,	ertification:	1 ☐ Natūral 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur			М	10,	Yes 2	No	28f Location /	Street and Nu	nher or Rura	il Route Number,
Div	s after al Direct	Certif	4 Homicide determined	building, etc.		, 101111, 3(1	eet, lactory	Ollica			City or Tox		77001 01 7 1010	, riddio rvanioci,
	To the Hoapital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Example)	sician: To the best of ner: On the basis of e and manner state	examination	dge, deat and/or in	vestigation,	in my op	oinion, dea	d place, th occur	red at the time.	date and plac	e, and due to	the cause(s)
	To T Com	Σ	29b. Signature and fittle of certifie	I n	প্য		290	License	number	1/	5	29d. Date sig	ned (Month,	Day, Year)
J.	Ś			omplified cause of dea	ath (Item 23	а) (Туре, а I	Print)	7(2)	wa	1	Ann	المص	is w	10 21401
Ĭ	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registrar	's Signature		born	6/	/	<i>/ </i>	- J + W V	1		

			1 - For State Ragistrar	State of M	aryland		artmen rtificate			and M	-	giene	nni	. 2570	a a
	Physici	an	1. Decedent's Name (First, Middle, La.	st)							2. Date of De Month		<u>U () </u>	3. Time of E	
	/Medi		Joyce Julia Fle								August	16	2	001 6-17	AM
	Examir	er	4a. Facility Name (If not institution, give	,					Location o	of Death	9		Sounty of		
	Funeral		Anne Arundel Me 5. Social Security Number 6. S		iter ge (In yrs. la	st birthday)	An1	napo 1 Year	L1S If Under 2	24 Hrs.	8. Date of Birt	th		runde1	Foreign
	Director		230-34-9978 ¹ Usual Residence of Decedent	□м 2ХСХЕ	74	Yrs.	Months	Days	Hours	Min.	Aug. 7	, Year) 193	0 1	Birthplace (State or Country) Kentucky	
	nyland how	_	10a. State 10b. County		10c. City,	Town or Lo	cation			, ,				10d. Inside City	Limits
	Be-f s	Director	MD Anne Art	ınde1		Odento	on							1 Tes	2 X No
	be filed within 72 hours after death with the Maryland tat Hygiene. od other then "neturel", or Items 23e or 28e-1 show event, the Marical Examine meturel te notified at		10e. Street and Number 980 Patuxent Roa	ıd			10f. Zip	Code 2111:	3			_	en of Wha	t Country?	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	i. 13. V	Was Deced	ent of Hi	spanic Orig	gin? (Spe	city Yes or No- Rican, etc.)	- 1		American Indian,	
36	rs after	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 222 If Yes, Give Year or Dates:	No	1	Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	moun, etc.)		Specify:	White, etc. White	
9	2 hour	ted t	15. Decedent's Ed	lucation		16a. Deced	lent's Usua	I Occupa	ition			16b. Kin	d of Busin	ess/Industry	
215	ithin 7 96.	Completed	(Specify only highest gra	de completed) College (1-4or:	5+)	(Give life. L	kind of wor DO NOT us	k done d e retired)	u <i>ring m</i> ost	of workii	ng			,	
121	e filed wall Hygier other the		8 17. Father's Name (First, Middle, Last)			Homer	naker		40 14-15-	4. 11.	(F) . A (; 1)		n Hor	ne	
Maryland 21215-0036	should be fand Mental H s marked of umatic ever	То Ве	Ulis Shelby								(First, Middle, entry	Maiden S	iumame)		
ary	2 should be and Mental Is marked raumatic ev	-	19a. Informant's Name/Relationship (ype, Print)		19b. Mailin	g Address	(Street a			l Route Numbe	or, City or	Town, Sta	te, Zip Code)	
≥,	and 2 ealth a m 27 I		James Clifford l	leming (H					nt Ro	ad,	Odentor	ı, MD	2111	L3	
Baltimore,	ges 1 If iter or oth		20a. Method of Disposition 1	Removal from State		ice of Dispos metery, crem	sition (Nam natory or ot	e of her place			ate	20c. Loca	ation - City	or Town, State	
Ħ	artmer artmer ortant injury	Ť	' 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Servi 1 is 6		Mar	yland					-2004		ltenl	nam, MD	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic es		23a. Part1. Enter the disease, or com	·			12 R:	idge	ly Av	enue	Home P. , Annap	olis	, MD	21401	
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	ech g a conseque		w							Interval Betwe	
.O. Box 68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Due to (or as d	of pregnand	cy eath 3	Ectopic pre Other (spe					23	d. Date of Month	delivery Day Yea	ar
Ω.	es that the digned by the be detached		Part II. Other significant conditions co	ontributing to death b	ut not result	ing in the un	derlying ca	use giver	n in Part I.		23e. Did to	bacco use		e to the cause of dea	ith?
ord	w requir been si should	eted								_	1 🗆 Y	es 2	No 3	Probably 4 DUnk	known
al Records,		Completed									24a. Was a autops perform	sy		e autopsy findings ava to completion of caus 1? /es 2 \(\text{No} \)	
Vital	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othor			Check on or				
Division of	ding Physicien: The h. h. After this certificate hi funeral director, page	tion: To	1 Yes 22 No 27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	1 Impatie 28a. Date of Inju (Month, Day	ry 2	NOutpatient 8b. Time of Injury		c. Injury	at INUIS	2	ne 5 Reside 8d. Describe ho			Specify)	-
ivisi	or Attend ifter death Director: A in by the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At hom c. (Specify)	e, farm, stre			53 2 14		8f. Location (Si City or Town	treet and l n, State)	Vumber or	Rural Route Number	r,
	To the Hospital or Attending Physicien: white 24 hours after death. To the Funerel Director: After this certification the funerel director, to the funerel director, to the funeral director, the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director of the function of the function of the funeral director.	Medical Ce	29a. Certifier (Check only one)	rsician: To the best of the basis of and manner sta	examinatio	edge, death n and/or inve	occurred a	t the time	o, date and nion, death	place, a	nd due to the ca	ause(s) ar	nd manner ace, and (as stated, due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier				29c.	License	number		2	9d. Date s	signed (Mo	onth, Day, Year)	
			1 Hardland		M-D.		Po	0966	58			Augu	at I	6. 2004	
(1		30. Name and address of person who co	ompleted cause of d	eath (Item 2	3a) (Type, P	in Pa	ten	ay,	Ann	if dis,	md	214	01	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 20	04 32. Registra	ar's Signatur	6	Spo	als	1		*.				

			1 - For State Registrar	State of M	1arylan		artment of rtificate o				ene 1. No2 () () (;	25800
	Physici /Medic		1. Decedent's Name (First, Middle, La John Sc	sı) Cott Fra	nk				2	2. Date of Death Month August	Day 16, 200	Year)4	3. Time of Death 10:30 p ^M
	Examin		4a. Facility Name (If not institution, giv 783 Woodsman Cin		r)			mpstea	d			arro	
	Funeral Director		5. Social Security Number 218-88-8870 Usual Residence of Decedent	Sex 7. A	45	ast birthday) Yrs.	If Under 1 Ye Months Day		Min.	B. Date of Birth (Month, Day,) Mar 29,	1959		lace (State or Foreign htry) ylana
	Maryland a-f show	ctor	10a. State 10b. County Maryland Carr	coll	10c. City	, Town or Lo	cation	Hamp	stead			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the	Funeral Director	10e. Street and Number 783 Woodsman Ci	rcle			10f. Zip Cod	210	74	100	g. Citizen of W	hat Coun USA	itry?
920	urs after dea al', or Itams	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? No		Was Decedent of Yes, specify C			ify Yes or No- can, etc.)		, White,	an Indian, etc. white
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23s or 28s-1 show event, Ira Medical Examination in that be mailing at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		r 5+)	(Give life. L	dent's Usual Oc kind of work do DO NOT use rel laterial	ne during mos tired)		16	Board Board		·
Maryland 2	be de la la la la la la la la la la la la la	To Be C	17. Father's Name (First, Middle, Last Harry T. Frank					V	ictor	First, Middle, Ma	er		
	d 2 sh th and 7 is rr traum	10	19a. Informant's Name/Relationship of Donna L. Frank,			1				Route Number, C AMPSTEAC			Code)
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 sny injury or other once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		e C6	emetery, cren	sition (Name of natory or other p nurch Ce	place)	Dai /21/		c. Location - C Lyrone ,		wn, State
Balti	permit. Departn Importe sny inju		21. Signature Fureral Service Lice	week of the contraction of the c	100723	3 22	Name and Ad		. 13	line Fur , Hampst			.074
68760,	Physician: The law requires that the death certificate be executed X X X X X X X X X X X X X X X X X X X	edicai Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a	is a consequence of the conseque	tage uence of) uence of;	Live		anc				Approximate Interval Between Onset and Death
P.O. Box	it the death certific by the attending p tached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregna Other (specify)				23d. Date Mont		ry Day Year
	quires that n signed b	by	Part II. Other significant conditions	contributing to death	but not resu	ulting in the ur	nderlying cause	given in Part I	l.	•	1 41		e cause of death? ably 4 Unknown
Division of Vital Records,	: The law require cate has been signage 2 should t	Completed							_	24a. Was an autopsy performe	d? de	or to con ath?	osy findings available inpletion of cause of
Vita	Physician: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ fnpa	tient 2 1	ER/Outpatien	t 3 DOA	Othor		Check only one)	ce 6 □Other	(Specify	')
ion of	of or Attending Physical distributions of the thick of the thick of the thick of the the the thick of the the thick of the	ation: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		jury Jay Year)	28b. Time of Injury	1 V	njury at Work? Yes 2	28	d. Describe how			,
DIVIS	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not to determined	286. Place of f	njury - At ho etc. <i>(Specif</i> y	me, farm, stre	eet, factory, office	се	28	f. Location (Stree City or Town, S		or Rurai	Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medicai	29a. Certifier 1 Certifying P. (Check only one) 2 Medical Exa	nysician: To the bes miner: On the basis and manner:	of examinat	wledge, death ion and/or inv	occurred at the vestigation, in m	e time, date an ny opinion, dea	nd place, and ath occurred	d due to the caus at the time, date	se(s) and mani a and place, an	ner as sta d due to	ated. the cause(s)
)	Variety of the state of the sta	W	29b. Signature and vitle of certifier	CO				nse number	962		. Date signed (1	
_	\ 0		30. Name and address of person who	on Ah	nn	1. D.	Print) 1130	Belt	mor	e Bluc	l we	mi	nsta air
- 5%	Sta Registi		31. Date filed (Month, Day, Year) AUG 18 2	32. Hegis	strar's Signal	y A	we					21	157

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day WILLIAM JOSEPH HAGINS Year Physician Month A M 14, 2004 Aug /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5530 Hodges Road Eldersburg Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1∭ M 2□ F 217-16-5536 79 19, Director 1924 Georgia Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show itam 27 is markad othar then "natural", or items 23e or 28e-f shov other traumetic avant, the McClcal Examinar must be notified at 1 X Yes 2 No Maryland N/A Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1804 South Charles St., 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Mayes 2 No If Yes, Give Year or Dates: WW 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Completed by White 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Union Local 101 Elementary/Secondary (0-12) College (1-4or 5+) Construction 6 0 permit. Pages 1 and 2 should be file Department of Heath and Mental Hy, important: If itam 27 is marked othrany injury or other traumetic ayant, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First Middle Last) Be Clifton W. Hagins Mabel B. Standiford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Hagins 5530 Hodges Rd., Eldersburg, Md. 21784 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. Pk. 8/17/04 `4 □ Donation 5 □ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kevin E Ecker McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave., Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metrestatus /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): use as the burial-transit The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 should be 4 Onknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No this certificate has page 1 ☐ Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Son s \square Home 1 Tes 2010 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death 2 Accident investigation the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of contifier Fort Ave, Balto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 901 eunis sus 32. Registrar's Signature

Registrar

			State of Maryland / Department of Health and N	lental Hygi	ene	0.111
			1. Decedent's Name (First, Middle, Last)	Reg	1. No.	25802
	Physic	ian	La La D	Month	Day Year	3. Time of Death
	/Med Exami		4a Facility Name (If not institution, give street and number) 4b. City, Town, or Li	ocation of Death	4c. County of Death	10:25 PM
	Exami	Hei	MANOR CARE - ROSSVIlle ROSSVI	110	BALTIP	MPE
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign
в	Director		218-96-3537 1 M 200 F 76 Yrs. Months Days Hours Min.	2-7-2	8 MAK	YLAND
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	- /		10d. Inside City Limits
	Aeryle f sho	ō				1 ☐ Yes 2 No
	28a	rect	10e. Street and Number 10f. Zip Code	100	. Citizen of What Cour	
	3a or	0	12 Elmont Are. 21206		1154	
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ	
0	or he	F	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ Yes 2 □ No 1 □ Yes 2 □ Yes 2 □ No 1 □ Yes 2 □ Yes 2 □ Yes	Hican, etc.)	Black, White,	etc.
215-0020	72 hours efter death with the Meryland naturel, or items 23a or 28a-f show dical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: UN	114.
7	n 72 h	ete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work (Ind. of work done during most of work (Ind. of work done during most of work (Ind. of work done during most of work done during most of work (Ind. of work done during most of work	ing 16	b. Kind of Business/In	dustry
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an	Mentel Mentel arked o	To Be	CHANGOCI HINZ AUDICE	11/ 4	1:11	
Maryland	2 should end Men is marks	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, C	City or Town, State, Zip	Code)
	1 end 2 Health e		Dorothy Biemiller-niece 5622 North Ln. BA	LTIMORE	MD 21	206
ore	of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or To	wn, State
Ë	Pages ment of lant: If ite		4 Donation 5 Other (Specify) Cardens of Faith Concept	18-17-04.	Rosedal	e MD
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Meryler Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene important: if Item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notitied at ann Defice.		21. Signature of Funeral Service Lio nsee 22. Name and Address of Facility	JiMONI	OM, MD 21	093
	20500		Kimberly y. Zawistny PEACEFUL ALTERNAT	IVES FUL	VERAL CK	EMATICNET
			23a. Par 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac on shock, or heart failure. List only one hause on each line.	or respiratory arrest		Approximate Interval Between
	Physician /Medical					Onset and Death
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		ſ	
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	tuted d ensit	Examiner	Sequentially list conditions. 6. Confrenous Chole cyships Due to (or as a consequence of):	ב יד	1	
ó	an en		Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		1	
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o.	res that the de signed by the e be deteched f	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did toba	cco use contribute to	the cause of death?
<u>α</u>	thet ti ed by detec	된	Corebrovascular Accident	1 ☐ Yes	No 3□ Prot	pably 4 Unknown
Sp.	uires sign ild be	d by	Peripheral vascular diseaso.	24a. Was an a	utopsy 24b. We	ere autopsy findings
2	w require been sign	Completed	Pripheral vascular diseaso	performe	d? ava	ailable prior to npletion of cause death?
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ta		BeC	25. Was case referred to medical 26. Place of Death		QE NO IL	Yes 2 No
of Vital Records,	Physician: The lew this certificate has be rel director, pege 2 s	To B	examiner?		e 6 □Other (Specify	()
	g Ph		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		<u></u>
iğ	ath. or: Aff	atlo	2 Accident investigation M 1 Yes 2 No			
Division	r Atter de l'recte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rura State)	Route Number,
Ω	oltal o urs al urs al illed i					
	Hose 24 ho Fune stely f	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a construction of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a construction of the basis of	and due to the caus ed at the time, date	e(s) and manner as stand place, and due to	ated. the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, L	
	F ≯ F ŏ		DEDIZA ALL LO DILL MA		SILINA	
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		· LI WILL Y	
	0		M. Chardon 7845 Dalcwood load Gl	eu Bl	unie, x	15 21061
2	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
1	Regist	ar	AUG 1 8 2004 Renewa & Assay			

DHMH 16 Rev 6/95

		For State Registrar	State of Marylar		ent of Health ar ate of Death		iene _{eg. No} 2004	25803
Physicia /Medic		Decedent's Name (First, Middle, Last)	Bernad	ette	Hart	2. Date of Deat Month	Day Year	3. Time of Death
Examin		4a. Facility Name (If not institution, give str	Vursing (enter	130011	nore	4c. County of Death	
Funeral Director		5. Social Security Number 212–09–6942 6. Sex Usual Residence of Decedent	7. Age (If) yrs.	Month		Min. 8. Date of Birth (Month, Day, July 3,	Year) Co.	nplace (State or Foreig untry) yland
Maryland -f show	tor	10a. State 10b. County MD N/A		ity. Town or Location Baltimore				10d. Inside City Limits
with the	Funeral Director	10e. Street and Number 1447 Andre Street			Zip Code 21230	1	0g. Citizen of What Co USA	untry?
s 1 and 2 should be filed within 72 hours after death with the Maryland it Heath and Mental Hygiene. It Heath and Mental Hygiene item 27 is marked other than "natural", or lieme 23a or 28a-f show other traumatic event, the Medical Examinar must be multiped at	by	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origi pecify Cuban, Mexican, 2 X No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
d 2 should be filed within 72 hours at the and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exam.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+)		work done during most of use retired) none Operate	of working	16b. Kind of Business/I Telephone	,
2 should be file and Mental Hy is marked oth aumatic event	To Be	17. Father's Name (First, Middle, Last) Michael Hart			Bri	s Name (First, Middle, M dget McHal	e	
ermit. Pages 1 and 2 shr Department of Health and mportant: if item 27 is m iny injury or other traum INGE.		19a. Informant's Name/Relationship (Type Josephine Lebrun /	Niece	7135 Pri	incess Lane	or Rural Route Number Pensacola		
Page nent o snt: tf		20a. Method of Disposition 1		Place of Disposition (f cometery, crematory of W Cathedra	Name of or other place) al Cemetery	August 20,	20c. Location - City or Baltimore	
permit. Page Department o Important: If any injury or once.		21. Signature of Foreral Service Licensee	\$	Cha	and Address of Facility Arles L. Ste Ol East For	evens Funer t Ave Balti	al Home In more MD 21	C. 230
Physician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	monio	node of dying, such as ca	ardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
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cate be executed bhysician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consec	quence of):				
ne death certifi the attending I hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	. If yes, outcome of pregn 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3 Dectopio			23d. Date of deli Month	very Day Year
uires that th n signed by Id be detac	by	Part II. Other significant conditions contr	buting to death but not re-	sulting in the underlyin			pacco use contribute to	the cause of death?
sician: The law requires t certificate has been signe rector, page 2 should be o	Completed	Parkinson's	diseas	e		24a. Was a autops perform	y prior to o ned? death?	topsy findings available topsy findings available to the completion of cause of a large to the cause of the c
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To the Hospital or Attending Ph within 24 hours after death To the Funeral Director Atter thi completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Exemine	ian: To the best of my kn r: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and ion, in my opinion, death	place, and due to the ca occurred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within To the Comp.	ž	29b. Signature and title of certifier	y'no		29c. License number	391 A	9d. Date signed (Month	o, Day, Year)
10		30. Name and address of person who com	deted cause of death (Ite	om 23a) (Type, Print)	Baltin	nove M	ary (cind	2122
Sta Registr		31. Date filed (Month, Day, Year)	32. Begistrar's Sign	nature 4			1	

			For State Registrar	State of Mar	yland	-	tment of		nd Mei		giene	004	25804	8
			1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dea			3. Time of Death	
	Physicia	an	D - 1		T 1				١,	Month	Day	2004	2:00	М
	/Medic	-		4	Jacks		4h Cihr Tourn	or Location of I		Aug.	14,	2004 County of Death		_
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	0		Usual Residence of Decedent							377				
	ylan Mor		10a. State 10b. County	1	0c. City,	Town or Loca	ition						10d. Inside City Limit	(S
	Mar Mar	tor	Maryland Anne Ar	ındo1	C1 o	n Burn	io						1 ☐ Yes 2 🔣 N	0
	28e	Director	10e. Street and Number	III.	_016	прил	10f. Zip Code				10g. Citiz	en of What Co	untry?	
	within 72 hours after death with the Maryland one. Than "natural", or Items 23a or 28e-f show To Medical Evariation hant be notified at	ቯ	121 т					21060				II C A		
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	er de	n	11. Marital Status	Armed Forces?	BI III 0.5.	If Y	es, specify Cu	f Hispanic Origir ıban, Mexican, F	Puerto Ric	an, etc.)		Black, White		
9	or l	by F	1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give		10	Yes 2⊠N	o Specify:				Specify:		
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Maryland	12 s h an 7 ls trau			(C)			,					1.00	,	
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altimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licen	S00		22 h	Name and Add	rece of Facility	- 11					
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			shock, or heart failure. List only	4		2							Interval Between Onset and Death	
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ecords,	uires I sign									1 □ Y	′es 2 🗆	No 3 Pro	babiy 4 Unknow	/n
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ec	law las b	ğ								24a. Was autop	sy	prior to c	opsy findings available ompletion of cause of	10
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Vital	sician: The law certificate has l irector, page 2 s	0	25. Was case referred to medical					26. Place of	of Death (C	Check only o	ne)		1	
	ysica is ce direc	To B	examiner? 1 ☐ Yes 2. ☑ No	Hospital: 1 Appatient	2 □ EI	R/Outpatient	3 DOA	Other: 4 Nursi	ing Home	5 🗆 Resid	lence 6	Other (Spec	ify)	
ō	Physical Control		27. Manger of Death	28a. Date of Injury	2	28b. Time of	28c. In	jury at		d. Describe h			.,,,	
2	ding P. h. After funer	io	1 Natural 5 Pending	(Month, Day Y	'ear)	Injury		lork? □Yes 2□No	0					
Division of	or Attendiater death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be		Athom	a form street				Location /S	troot and	Number or Ru	ral Route Number,	
≥	after of Direct of in by	ŧ	4 ☐ Homicide determined	28e. Place of Injury building, etc.		ie, iaim, stree	R, lactory, offic	e	201.	City or Tow	m, State)	INDITION OF THE	ar riogie ivarrioer,	
	ital Irs a rel E		,											
	hou hou une une ily fil	Cal	29a. Certifier 12 Certifying Ph	ysician: To the best of a niner: On the basis of e	my knowl	on and/or invo	etination in my	aninion death	occurred:	at the time of	date and r	aub bos each	to the cause(s)	
	To the Hospital or Attending Physician: within 24 hours atter death. To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	one)	and manner state	d.	and or mive:	onyanon, m m)	Johnson, Utrath	Joouriad		-aco and	Javo, and due		
	Nithii Fo th	Ž	29b. Signature and title of cortifier	2 1			29c. Lice	nse number			29d. Date	signed (Month	, Day, Year)	
	. >= 0		X LITTE	Vienn	hai	_		124	804		8	-14-2	004	
•	14.		20 11000 1 00		MA	220\ / Time = 1	int)	6	,			1		
	10,1		30. Name and address of person who	tersen	th (Item 2	n (Type, Pr	Atus	nse number D24	tun.	enela	M	d 214	12/	
	1		31. Date filed (Month, Day, Year)	32. Registrar		<u>ソ </u>	10110	- //	-101	1	, ,	ι ι	*	_
	Sta	ite rar	ALIC 1 8 2004	And And And And And And And And And And	Jugilau	1 ho	Bakal							

State Registrar

31. Date filed (Month, Day, Year)
AUG 1 8 2004

>. K

32. Registrar's Signature

30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

Spals

111 Penn Street, Baltimore, Maryland 21201

KNO!	√N 04-2	78	For 1 - State Registrar	State of Maryla		ment of Hea		-	giene Reg. No.2	004	258	06
	Physici /Medio Examin	al	Decedent's Name (First, Middle, L. Richard A. Facility Name (If not institution, girls SINAI HOSPITAL	D.	John	DSON b. City, Town, or Loc BALTIMO		2. Date of De Month AUG.	16, 2 4c. Cour	Year () () 4 Inty of Death	3. Time of I	Death A M
	Funeral Director		5. Social Security Number 6. 315-94-1348 Usual Residence of Decedent	112M 2DF	40 Yrs.	If Under 1 Year If Indonths Days H	Under 24 Hrs. lours Min.	8. Date of Bin (Month, Da	N/A 1964	Mar	ilace (State or htry) Ylarra	
	ith the Marylan or 28e-f show	irector	10e. Street and Number	Prundel	Glen C	Surnie 10f. Zip Code			10g. Citizen o		0d. Inside Cit 1 ☐ Yes ntry?	
98	within 72 hours after death with the Maryland sne. then "neturel", or Items 23s or 28e-1 show ha Medical Exandrat rust be trofflied at	y Funerai Director	2/7 War Fiel 11. Marital Status 1. Dever Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give		s Decedent of Hispares, specify Cuban, N	nic Origin? (Spe Mexican, Puerto	ecify Yes or No Rican, etc.)	USA 14. FI B	lace - Americ		
21215-0036	within 72 hours ane. then "neturel', ha Medical Ex	Completed by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest g	Year or Dates:	16a. Deceder	nt's Usual Occupation of of work done durin NOT use retired)	ng most of worki	ing	16b. Kind of	Business/Ind		
Maryland 2	ould be filed Mental Hygi arked other stic event, I	To Be Co	17 Father's Name (First, Middle, Las	ohnson	dob Malling	7.	Mother's Name	Moi	Maiden Sum	ame)		
			19a, Informant's Name/Relationship Delima	t -mother 201	2/7 b. Place of Dispositi	Address (Street and a ArField on (Name of tory or other place)	Rol. G.	len Bur,	OIE ML 20c. Locatio) 2/0 n - City or To	060 own, State	
Baltimore,	permit. Page Department o Importent: If any injury or once.		4 Donation 5 Other (Special Signature of Ineral Service Local Control of Cont	ity) [[1t. Zion 22. N	Cemetery lame and Address of P. March	B-23 FIH 27		Lansdo Ibn Riss	when		21729
	Pnysician /Medical	S 1	23a. Party Eproythe disease, or co shock, or heart failure. List on Immediate Cause (Final disease or Indition resulting in death)	nplications that caused the dy one cause on each line. a. GUNSTOT Due to (or as a con-	vvo Va		BACK	or respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a con: Due to (or as a con:	sequence of):							
68760,		cai	IF FEMALE:	d								
.O. Box	at the death certifical by the attending phy tached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3 E	etopic pregnancy other (specify)				Date of delive Month		ear
ords, P	Physicien: The law requires that the this certificate has been signed by the rat director, page 2 should be detached.	by	Part II. Other significant conditions	contributing to death but not	resulting in the unde	erlying cause given in	n Part I.		obacco use co	3 🗌 Prob		nknown
ital Rec	ysicien: The tav is certificate has director, page 2:	Be Completed	25. Was case referred to medical examiner?			26	i. Place of Death	autor perfo	osy ormed? 2 \(\text{No} \)	prior to condeath?	npletion of ca	use of
Division of Vital Records,	ding After fune	P	1X Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Injury (Month, Day Year	2 ER/Outpatient 28b. Time of Injury 10: 43 P	28c. Injury at Work?	4 ☐ Nursing Ho	me 5 Residence R	now injury occ	urred		
Divisi	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not determine	28e. Place of Injury - A building, etc. (Sp	At home, farm, stree ecify)	t, factory, office	į.	28f. Location (: City or To	wn, State)	NON B	LV0, 40	
	To the Hosp within 24 hou To the Fune completely fi	Medicai	(Check only one)	Physician: To the best of my aminer: On the basis of exam and manner stated.	knowledge, death o nination and/or inves	stigation, in my opinio	on, death occurr	ed at the time,	date and plac	e, and due to	the cause(s)	
	With To Con	2	29b. Signature and title of certifier			29c. License nu O.C.			29d. Date sig AUG	. 17,		
				12.00	111, Penn	street, l	Baltimo	re, Mar	yland :	21201		
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registrar	ignature							

			1 _ State	State of Maryland /	Department of Health Certificate of Deat		giene	N. 25907
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) ESIE B	Ja	ckson	2. Date of Do Month		3. Time of Death
>	Examin		4a Facility Name (If not institution, give st AUGS DUTG LUTHE	eran Home	4b. City, Town, or Location LOCHERN		Ba/7	timore
	Funeral Director		5. Social Security Number 6. Sex 15 28 - 89/3	M 2 F 7. Age (In yrs. last I	birthday) If Under 1 Year If Under 1 Year Amonths Days Hour	der 24 Hrs. 8. Date of Bi S Min. (Month, D	7, 1907	9. Birthplace (State or Foreign Country)
	Maryland I-f show	tor	10a. State 10b. County MD Baltimor		own or Location (BSVI)/E			10d. Inside City Limits 1 Yes 2 10
	th with the 23e or 28e ist be noti	Funeral Director	10e. Street and Number ROCKRI	1 21	10f. Zip Code 2/209		10g. Citizen of V	What Country?
036	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "naturel", or items 23e or 28e-f show event, the Medical Excitains interest in collined at	by	11. Marital Status 1: 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	can, Puerto Rican, etc.)		e - American Indian, ck, White, etc. VB/ACK
Maryland 21215-0036	d within 72 ho plene. r than "natur the Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)		ia. Decedent's Usual Occupation (Give kind of work done during m filte. DO NOT use retired) - OME MAKER	nost of working	Home	usiness/Industry
land 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Frank Blown+		18. Mc	other's Name (First, Middle	e, Maiden Suman	10)
, Mary	and 2 sho ealth and N n 27 Is ma		19a Informant's Name/Relationship (Typ	- Son	9b. Mailing Address Arreet and Nur 7407 KOCK Ric	dge Rol. Pik	esville, 1	no 2/309
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or Items 23e or 28a-f show any injury or other treumetic event, the Madical Examt is a must be notified at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service	emoval from State	of Disposition (Name of tery, crematory or other place) Star Morning Star Cemi 22. Name and Address of Fa		Fort NE	city or Town, State PCISSITY, Louisiums alto, MD 21229
	Physician /Medical		23a. Party Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. De cause on each line. Due to (or as a consequence	evosilenty ca	as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
8760,	Examiner be executed bhysician and sthe burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence				
.O. Box 687	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 52 No 9 Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown			1	te of delivery nth Day Year
Ω.	es that igned b	by	Part II. Other significant conditions cont	ributing to death but not resulting	g in the underlying cause given in Pa			ribute to the cause of death? 3 ☐ Probably 4 ☐Unknown
Records,	The ate h	Completed				24a. Was auto perf 1 🗆 Yes	opsy ormed?	Were autopsy findings available prior to completion of cause of death? I □ Yes 2□ No
on of Vital	ding Physicien: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation					
Division	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		(Street and Numb wn, State)	er or Rural Route Number,
	the Hospitel hin 24 hours a the Funerel I npletely filled	Medical (29a. Certifier 1. ☐ Certifying Physical (Check only one) 2 ☐ Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	ige, death occurred at the time, date and/or investigation, in my opinion, o	and place, and due to the death occurred at the time	cause(s) and ma , date and place,	inner as stated. and due to the cause(s)
•	To the P within 2 To the I	Ž	29b. Signature and title of certifier	× ~	29c. License number	9r 7 5 7 3	29d. Date signed	(Month, Day, Year)
	4		30. Name and address of person who con	mpleted cause of death (Item 23:	a) (Type, Print) St. Reisterst	on MO	21136	
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 8 200	32 Registrar's Signature	Aparte			

			State of Maryland / Department of Health and M State of Maryland / Department of Health and M Registrament ITEM #23a-c PER PHY G834 rtill cate of Death	lental Hygiene	/ H H H H D T D D D D
	0;-		Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia /Medic		KTOUISE DELURES JONES	August 1	2 2004 0909 AM
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	40	. County of Death
			Union Memoreal Hospital BAltimone		N/c
н	Funeral		5. Social Security Number 6. Sex 1 M 32 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	
	Director		Usual Residence of Decedent	April 4, 1932	2 Alabama
	show		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	a-f sl	ctor	MD Na BAHMONE		1 Pres 2 No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g. Cit	tizen of What Country?
	ath w	ral	1707 & 35th Staret 21218		US.A.
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 1 ☐ Yes 2 ☐ No Specify:		Specify: Alamae
5-0036	72 hours after death with the Maryland natural", or Itams 23a or 28a-1 show digal Excentive neather notified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. K	(ind of Business/Industry
215	within 7; ene. than "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Give kind of work done during most of working iffe. DO NOT use retired)	ng	•
2121	filed with Hygiene. Ither than	Con	12 O MURSE And		631NG
Ind	be filk tal Hy d oth avant	Be		(First, Middle, Maiden	Sumane)
Maryland	should be ind Mental marked c	ဥ		Known	
Mai	12 sho h and 7 la mu trauma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	1.0000	
_	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If itam 27 is marked other than "naturat", or itams 23a or 28a-1 show or other traumatic avant. The Medical Examble countilled at		MURKIS REWIS 1707 & 35th Street 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)	BA HIMONE Date 20c. L	ocation - City or Town, State
Baltimore,	ages ont of t: If it		1 Gurial 2 Cremation 3 Removal from State **Donation 5 Other (Specify) **Comparison 5 Other (Specify) **Comparison 5 Other (Specify)		
	permit. Pages Department of Important: If i any injury or once.	ı	** Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3	104 1001	Homes MD
B	permit. Departr Imports any inju		Potucia Bests 1129 N. CARVINE 5		1 MD 21213
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.		Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition ASPTRATION P	ATMONTA	Onset and Death
4	/Medical		resulting in death) a Due to (or s a consequence of):	ALKALAMILIA	10years
	Examiner		Sequentially list conditions, b. CEREBRAL VASC	CULAR ACCTU	decomposition of LECT
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	25:05	1001005
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):	HEMI	to deur
8760	icate be ex physician s the buria	dical	C ₁		
9	tificate ig phys as the	0			
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the post 10 months? 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	the att	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	OS- Did tabasas	
S,	signed I	l by	Hy pertunions commonly to deal out not resulting in the underlying cause given in Part.	1 ☐ Yes 2	use contribute to the cause of death? No 3 Probably 4 Nunknown
Records,	w requir been si should	Completed			
Rec	ne lav has ge 2	ldm	Hypunatrenin	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	icate	ို့	25. Was case referred to medical 26. Place of Death	1 Yes 2 No	1 ☐ Yes 2 ☐ No
>	= 0				6 COther (Specify)
	raician: Th s certificate director, pag	0 0	examiner? 1 Yes 2 No	ne 5 Residence	
J of	Phys this al dii	To B	1 Yes 2 Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Hor 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c. Time of 28c. Time o	ne 5 Residence 28d. Describe how injur	
ion of	ding T. After fune	To B	1 Yes 2 No Hospital: 1 Inpatient 2 R/Outpatient 3 DOA Other: 4 Nursing Hor 27. Manner of Death 1 SNatural 5 Pending 2 Accident		
ivision of	ding T. After fune	To B	1 Yes 2	28d. Describe how injui	ry occurred Id Number or Rural Route Number,
Division of	ding T. After fune	Certification: To B	1 Yes 2 To	28d. Describe how injure 28f. Location (Street an City or Town, State	ny occurred and Number or Rural Route Number,
Division of	ding T. After fune	Certification: To B	1	28f. Location (Street an City or Town, State	ny occurred and Number or Rural Route Number,
Division of	ding T. After fune	To B	27. Manner of Death 1 Natural 2	28d. Describe how injure 28f. Location (Street and City or Town, State and due to the cause(s) and at the time, date and 29d. Da	nd Number or Rural Route Number, and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year)
Division of	To the Hospital or Attending Physiciar within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	Certification: To B	27. Manner of Death 1 Natural 2	28d. Describe how injure 28f. Location (Street and City or Town, State and due to the cause(s) and at the time, date and 29d. Da	nd Number or Rural Route Number, and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year)
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Division of	ding T. After fune	Medical Certification: To B	1 Yes 2 No	28d. Describe how injure 28f. Location (Street and City or Town, State and due to the cause(s) and at the time, date and 29d. Da	nd Number or Rural Route Number, and manner as stated. d place, and due to the cause(s) te signed (Month, Day, Year)

			1 - State Registrar	State of Maryland /	Department of F		ental Hygiene	2001. 3	25800
	Physici /Medic	- 0	1. Decedent's Name (First, Middle, Last)	= JOHNS	ON JR		2. Date of Death Month Da	3. T	ime of Death
	Examin	-	4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, o	r Location of Death	40	County of Death	
2000	Funeral Director		X14- 10 10 10		virthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year,	9. Birthplace (S Country)	State or Foreign
	Maryland s-f show filed at	tor	Usual Residence of Decedent 10a. State 10b. County HARFOR		hu eah	lle			side City Limits
	s or 284	I Director	10e. Street and Number	0	10f. Zip Code	1028	10g. Ci	itizen of What Country?	
980	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at	by Funeral		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No		cify Yes or No- Rican, etc.)	14. Race - American Indi Black, White, etc. Specify: White	ian, H
21215-0036	within ene. than	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	during most of working	16b. k	Kind of Business/Industry	00
Maryland 2	should be filed nd Mental Hygi marked other umatic event, I	To Be C		ison, SR.) //	Helga	(First, Middle, Maider	aut wur	st
	1 and 2 s Health ar em 27 is ther treu	5	19a. Informant's Name/Relationship (Typ. Pearl M. Johns 20a. Method of Disposition	on-wife.	b. Mailing Address (Street of Disposition (Name of	n, Churc	hville	or Town, State, Zip Code) 11 0 2 1 0 2 ocation - City or Town, St	8
Baltimore,	permit. Pages Department of Important: If It any injury or o		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	IEVANS	ery, crematory or other place of the CH CH CH 22. Name and Address NEW	H141-8-1	7-04 FOREST	PHICK, M ELAIR. O	mo
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Fin.)	se on each in.	not enter the mode of dyin	NERACCE ng, such as cardiac or IMDO	TAPEC- 16 respiratory arrest,	Appro	eximate ral Between at and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or a consequence	e of):	TO NOT DE I	(CULTO) CALERIA	e Grenovsky je	2 npo
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes or in jury that initiated events resulting in death) Last						
8760,	cate be executed physician and the burial-transit	Ical	d	Due to (or as a consequence	9 01):				
P.O. Box 6	that the death certificate be executed ted by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ⊟Ectopic pregnancy 5 □ Other (specify) _	1		23d. Date of delivery Month Day	Year
	sign d be	by	Part II. Other significant conditions con	stributing to death but not resulting	in the underlying cause giv	en in Part I,	23e. Did tobacco	use contribute to the caus	
Vital Records,	The ate h	Completed					24a. Was an autopsy performed?	24b. Were autopsy find prior to completion death?	n of cause of
Vit	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	Oth	26. Place of Death			
ion of	Attending Physic death. ector: After this by the funeral di	F 4	1 Yes 2 No 27. Manner eath 1 tural 5 Pending 2 Accident investigation		Time of 28c. Injury World	4 Nursing non	ne 5 sidence 8d. Oescribe how inju		
Division	in Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, the building, etc. (Specify)	farm, street, factory, office	2	8f. Location (Street ar City or Town, State	nd Number or Rural Route a)	Number,
	the Hospital nin 24 hours at the Funeral I	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowleds ner: On the basis of examination a and manner stated.	ge, death occurred at the tin ind/or investigation, in my o	ne, date and place, ar pinion, death occurre	nd due to the cause(s d at the time, date and) and manner as stated. d place, and due to the ca	use(s)
1	To the within To the comp	M	29b. Signature and title of certifier	tein MD	29c. Licens	e number	154 aug	te signed (Month, Day, Ye	204
1	()		30. Name and address of person who could be Louis Silve	rstein 805	S. Union	St. Have	ode Gra	ce MO 21	078.
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	6 1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1 Decedent's Name (First Middle Last) AUGUST **Physician** JOHNSON LUCILLE 1:43 PM 12 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE CITY N/A HOPKINS JOHNS HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛱 F MARYLAND 71 215-30-9308 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at No Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 21217 1741 N. CAREY ST. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give^{2-x} Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHERS ASSISTANT EDUCATION -12-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f h and Mental } EDWARD H. GROSS MARTHA A. CAREY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mit. Pages 1 and 2 partment of Health a portant: If Itam 27 lg / injury or other train EDWARD GROSS (BROTHER) 1617 W. NORTH AVE. BALTIMORE, MARYLAND 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 3 Removal from State mation permit. Page Department o Important: If any injury or once. 4 Donation Other (Specify) ARBUTUS MEMORIAL PARK 8-19-2004 BALTIMORE, MARYLAND 21. Signature of meral Service Licensee NONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME. P.A. 1721-27 N. MONKOE ST. BALTIMORE, MARYLAND 21217 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final ACUTE PESPIRATORY DAYS DISTRESS **Physician** /Medical resulting in death) Due to (or as a consequence of). Examiner ABDOMINAL INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed TUMOR ABDOMINAL and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan this certificate has 1□ Yes 1 🗌 Yes or Attanding Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the within 24 hours after deat To the Funaral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Exeminer: On the basis of examination and/or investigation, in my actions, death accurred at the cause(s) and manner as stated. 29a. Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ween 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YRAVEEN STREET BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 8 2004

			State of Maryland / Department of Health and	d Mental Hygie	ne O O O I O I O I O I I
			1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg.	Nd. U L 3. Time of Death
	Physici /Medi		Laurence S Kilby		Day Year 2:47 AM
)	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Di	eath	4c. County of Death
			5. Social Security Number 6-Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If	drs 8 Date of Sinh	NA
	Funeral Director			Hrs. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State of Foreign Country)
	put *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d Inside Ott Limite
	Maryla fed at	tor	mb Battimore Randoutstown	ſ	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th the or 28a	Director	10e. Street and Number	10g.	Citizen of What Country?
	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show diest Examinat be notified at		3530 Kescurce Drive 21133		USA
	ter de r Itams	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? It Yes, specify Cuban, Mexican, Pu	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ours af	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: BIACK
5-0	"natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	working 16b	. Kind of Business/Industry
121	filed within Hygiene. Ither than " Int, the Wes	ошо	Bementary/Secondary (0-12) College (1-4) F (1-4) College (7	etholopem Steel
	be filed tal Hygie d other	Be C	17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle, Maid	den Sumame)
Maryland	should be ind Mental s markad c	To		ie Thomas	S
Mar	C1 10 00		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street) 19c. Mailing Address (Street and Number of Street)	Rural Route Number, Cit	ry or Town, State, Zip Code)
ē,	es 1 and of Health if itam 27 ir other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Location - City or Town, State
imo	Pages ment of ant: if its ury or o		*4 Donation 5 Other (Specify)	18-04 1	monium MD
Baltimore,	permit. Pag Department Important: t any injury o		21. Signature of Funeral Service Licensee 22 Name and Addr ss of Facility	augno Cere	ene Funeral Snc.
	40340		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as care	diac or respiratory arrest	Approximate
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as carreshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease)	DUYTA	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (pr as a consequence of):	carr 10	near ancient
ı	Examiner	16	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
o,	e exection and an arrial-tra	Еха	resulting in death) Last Due to (or as a consequence of):		
8760	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai	d		
9 x	eath certific attending pi	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
. Box	death e atter	Physician/Me	in the past 12 months? 1		Month Day Year
P.0	that the de ed by the detached	Phys	9 Unknown		
	signed d be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Tes	2 No 3 Probably 4 Munknown
Records,	w require been signature should b	iete		24a. Was an	
Re	The lav	Completed		 autopsy performed; 1 ☐ Yes 2 ☑ 	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Vital	certificate harector, page	Be	examiner?	Death (Check only one)	A.
of	Phys this al di	- L		g Home 5 Residence	
ion	nding tth. r: After e fune	ation	27. Mariner of Death 1. Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	25d. Describe flow ii	nary occurred
Division	I or Attendi after death. Director: A I in by the fu	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Str	and Number or Rural Route Number,
Q	pltal o		/		,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate of the death occurred at the time, date and plate occurred at the time, date and plate of the death occurred at the time, date and plate occurred at the time, date and plate occurred at the time, date and plate occurred at the time, date and plate occurred at the time, date and plate occurred at the time, date and plate occurred at the time, date occurred at the time,	ace, and due to the cause ccurred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title bleetifier 29c. License number	290,1	Date signed (Month, Day, Year)
	,		(1011(DD) MD D0055	754 M	ugust 17,2004
	9		30. Name and address/of person who completed cause of death (Item 23a) (Type, Print)	on Mam	Ham Lav
	Sta	te	31. Date filed (Month, Pay, Year) 32. Registrar segnature		u lu lapila
	Registi		AUG 1 8 2004		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	State of Maryland / De		Mental Hygiene	001		
			State Registrar		ertificate of Death	Reg. No.			
	Physici /Medio		1. Decedent's Name (First, Middle, La	sinia Lewis		2. Date of Death Month Day	2004 7: 05 AM		
	Examin		4a. Facility Name If not institution, give 408 Crisfield	b street and number)	4b. City, Town, or Location of Dea		County of Death		
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthda	1.0	S. 8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)		
	Director		Usual Residence of Decedent	N 75		9/4/08	NE NE		
	e Marylar 3a-f ehow tiffed at	ctor	MD Harfo	ard Abin	adon, MD		10d. Inside City Limits 1 ☐ Yes 2 No		
	23a or 28	al Dire	408 Crisfield	ld Dr.	10f. Zip Code 21009		en of What Country?		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or Itams 23a or 28a-f ehow any injury or other traumatic evant. The Medical Examination in the Indifficular and once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	3. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 Yes 2 No Specify:	nto Rican, etc.)	4. Race - American Indian, Black, White, etc. Specify: Black		
215-0036	in 72 ho "natur	pleted	15. Decedent's E (Specify only highest gra	ade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of w . DO NOT use retired)	orking	d of Business/Industry		
1212	led within lygiene. har than "	Com	Elementary/Secondary (0-12)		acher-School		ucation		
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: If item 27 is marked other than 'any injury or other traumatic event. Item ADDG.	To Be	17. Father's Name (First, Middle, Last, Richard G	iles	Carr	Jiven Or.	ie Ellis		
Mar	nd 2 shi alth and 27 Is m		Roberta L. Clay	Type, Print) 19b. Ma Daughter 408	Crisfield Dr.	Rural Route Number, City or Abinadan	Town, State, Zip Code) MD 2/009		
nore,	ages 1 a nt of Hea t: If item / or otha		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □	20b. Place of Dis	position (Name of rematory or other place)		ation - City or Town, State		
Baltimore,	permit. Po Departme Important any injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice		22 Name and Address of Facility		coline St., Balto MD		
	20260		23a. Part 1. Enter the disease, or com	plications that caused the death. Do not of			Approximate Interval Between		
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a end sea	dente		Onset and Death		
	Examiner		Sequentially list conditions,	Due to (or as a consequence of):					
	uted d ansit	Examiner	any leading to introdiate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):					
68760,	cate be executed physician and the burial-transit	al Exa	resulting in death) Last	Due to (or as a consequence of):					
_		ledical		0.					
O. Box	he death certific r the attending p ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		B Ectopic pregnancy Description Other (specify)	2	3d. Date of delivery Month Day Year		
ds, P.O.	w requires that the de been signed by the s should be detached	by	Part II. Dther significant conditions of	contributing to death but not resulting in the	underlying cause given in Part I.		se contribute to the cause of death?		
Division of Vital Records,	2 S a	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
R	The ate	Con				performed? 1 ☐ Yes 2 ☐ No	death? 1 🗆 Yes 🏖 🗆 No		
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Othor	eath (Check only one)			
o		To it	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	Home 5 Residence 6 28d. Describe how injury			
ion	Attending r death. actor: After by the fune	atio	Natural 5 Pending investigation	n	Work? M 1 ☐ Yes 2 ☐ No				
Divis	al or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,		
	To the Hospital or Attend within 24 hours after death To tha Funaral Director: completely filled in by the	ledical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	ce, and due to the cause(s) a curred at the time, date and p	and manner as stated. place, and due to the cause(s)		
	To th To th compl	Me	29b. Signature and title of certifier	~	29c. License number	29d. Date	signed (Month, Day, Year)		
•	\		Dave	5 Dim	032259	Au.	305512,2001		
	V			completed cause of death (Item 23a) (Typ					
	Sta	to	31. Date filed (Month, Day, Year)	22. Registrar's Signature	MACPha,				
	Regist		AUG 1 9 200	167	ASC!				

			1 - State Registrar		artment of Health and M rtificate of Death	ental Hygier	DADI DEDIO		
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death		
	/Medio		Cynthia Lee 4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death	August	II 2004 655 PM		
	Examir	ier	Northwest Hospital	namour,	Randallstown		Batimore		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	Birthplace (State or Foreign		
	Director		320 P3 1273	SA Yrs.	Willis Days Tiours Will.	FZG.18, 192	CAPTERAM CE		
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits		
	Mary a-f sh	to	MARYLAND BENTTIMER	BALTIN	26:87		1 ☐ Yes 2 No		
	or 284	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?		
	ours after death with the Marylan ral', or Items 23a or 28a-f show Ezaminar muat be notified at		8411 WAYMEADOW		31244		U-S.A.		
	Items	Funeral	Armed	ecedent Ever in U.S. 13.1 Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
36	urs aft	by F	Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year o	s No Give Dates:	1 ☐ Yes 🏂 No Specify:		Specify: Q \ n=V		
21215-0036		ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16b.	Kind of Business/Industry		
21	S 6 3	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	(Give life.	kind of work done during most of workir DO NOT use retired)	ng			
	e filed with I Hygiene. other thai		8785	U(JEWBTOAZO				
Maryland		Be	17. Father's Name (First, Middle, Last)	1		(First, Middle, Maide	en Sumame)		
7	d 2 should be th and Menta 7 la marked traumatic av	은	Unknown 19a. Informant's Name/Relationship (Type, Print)	19b Mailir	on Address (Street and Number or Bure)	Boute Number City	or Town, State, Zip Code)		
	12 ha 7 le		JUOY L. OETTLOFF	4204	Serveriew AV	BALTIM 3	(A) - 1		
Je,	- I 5 5		20a. Method of Disposition	20b. Place of Dispo	sition (Name of D		Location City or Town, State		
imo	Pages nent of l ant: If its ury or o	١.,	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro `4 ☐ Donation 5 ☐ Other (Specify)	m State EVACE	matory or other place	1-04 Foo	COALSART LUH TZE		
Baltimoré,	permit. Pages Department of Important: If ii any injury or o		21. Skin Nere I Fune al Ser de Licens e	d	2. Name and Address of Facility	STEMBRI	NSTAM SIZORALIA		
ш	207		LAN MAS		MILL 2792 JOSK	16000 15 C	Errium MO. 21093		
В			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause o	it caused the death. Do not ent n each line.	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between		
	Pnysician /Medical	Œ Ø	Immediate Cause (Final disease or condition resulting in death)	BABLE VE	NICICALAR F.	BALLU	APPROXIMATION APPROXIMATE Interval Between Onset and Death ASCENSE ASSESSED		
	Examiner		Due	to (or as a consequence of):		10000	- December 181		
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a consequence of):	renojuiN871C	216	Wisconspic		
	outed Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			1)15 600	SE 7/1048		
oʻ	e exectan ar		regulting in death) I get	o (or as a consequence of):					
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9	eath certific attending p I for use as I	/Med	IF FEMALE:	outcome of programmy					
Вох	attendation	ian	in the past 12,months?		Ectopic pregnancy		23d. Date of delivery Month Day Year		
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0	es that gned b be deta	by Pt	Part II. Other significant conditions contributing to	death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?		
rds	w requires been sign should be	ed b	HYPENTENSION,)	ARENES MEL	LINES TYPEZ	1 ☐ Yes 2	2 No 3 Probably 4 Unknown		
900	e taw re has bee je 2 sho	plet	CHRONIC ASWAL IN	VSUBFICIEN.	WY A. (.).	24a. Was an	24b. Were autopsy findings available		
Ä		Completed				autopsy performed? 1 ☐ Yes 2 🗷 N	prior to completion of cause of death? o 1 ☐ Yes 2 ☑ No		
Vital Records,	Physician: this certifica al director, p	Be (25. Was case referred to medical examiner?		26. Place of Death				
of	S S =	To	THE STATE OF THE S	Inpatient 2 Ker/Outpatien			6 Other (Specify)		
O	iding Phy th. : After this funeral o	tion	1 Natural 5 Pending (M	se of Injury 28b. Time of Injury Injury	28c. Injury at 28 Work? M 1 ☐ Yes 2 ☐ No	8d. Describe how inju	ury occurred		
Division	tor tor the	fica	2 □ Suiside 6 □ Could not be	ce of Injury - At home, farm, str		Bf. Location (Street a	nd Number or Rural Route Number,		
Ö	in the	Certification:	4 Homicide determined but	ce of Injury - At home, farm, stri Iding, etc. (Specify)		City or Town, Sta	te)		
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	ledical C	(Check only 2 Medical Exeminer: On the	he best of my knowledge, death basis of examination and/or invanner stated.	n occurred at the time, date and place, ar restigation, in my opinion, death occurred	nd due to the cause(s d at the time, date ar	s) and manner as stated. Id place, and due to the cause(s)		
	To the vithin 2 To the Complei	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)		
•			Melesco ATTON	NING	1) 40390	Auc	145T 12. 2000		
0	3		39. Name and address of person who completed ca		Print) M. 732 DW.N	w Mill	1457 12, 2604 , MM 21/17		
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 2004	Registrar's Signature	Sparks	,			

Box 68760,
P.O.
Records,
Vital
Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month *Physician Year 1:10 PM 09 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL SAMARITAN IMORE BALTIMORE BALT If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 🕱 M 2 🗆 F 216-12 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other then "naturel", or items 23s or 28a-f show treumetic event, it a Medical Eraminer must be notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Director RKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 DRIVE NERGREEN 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced Specify: While Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 11 yes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental I assen JOHN 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 assen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ortent: If i 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Department or Importent: If i any injury or once. * 4 □ Donation /5 □ Other (Specify) 2004 21. Signatury Funeral Jervice Ucensee 22. Name and Address of Facility Valus FURLEW Chape 28a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician CARDIOMYOPAT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death. To the Funerel Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) · SSulattras MD RESODO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANUMURU, 5601 LO CHRAVENBUD, BALTIMORE, MD-21239 SRILATHA

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 1 8 2004 32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / L	Certificate of Death		gierie Reg. No: 1 1 1 1	25015
			1. Decedent's Name (First, Middle, Last)		2. Date of Dee	th CUU	3. Time of Death
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	/Medic Examin		4a Fecility Neme (If not institution, give street end number)	4b. City, Tow	n, or Location of Deeth		
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	Funeral		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 2		9. Bir	thplace (Stete or Foreign buntry)
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	permit. Pe Depertmar Important: any Injury any Injury	1	4 □Donation 5 □Other (Specify) 21. Signature of Funeral Services Licensee	22. Name and Address of Facility	5- 900H	imprini	1 INCOLUNIO
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>	Physician: this certific	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	0.0	sing Home 5 Reside		cify)
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Ö	s afte	E	4 ☐ Homicide building, etc. (Specify)		City or Town	r, State)	
	hour mere y fille	<u> </u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date end	place, and due to the ca	ause(s) and manner es	stated.
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificata ha completaly filled in by the funeral director, paga	edicai Certification:	(Check only one) 2 Medical Examiner: On the basis of exemination end and manner stated.	or investigation, in my opinion, death	occurred at the time, d	ate and place, and due	to the cause(s)
	Vithi To the	Σ	29b. Signature and title of cegifier	29c. License number		9d. Date signed (Mont	
			My Hothory Wiles in	10 D2520	1	4ugusT1	3,2004
	1		30. Name end address of person who completed cause of death (Item 23e) (Type, Print)	0 0	0 00	md 2120x
	~		W. A. Riley Gome	5701 N. Ch	mles It.	bally.	nd -1 20x
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		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	_last birthday) If Under 1 Year If Under 24 F	rs. 8. Date of Birth	Birthplace (State or Foreign
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		show	-	10a. State 10b. County		ity, Town or Location		1 ☐ Yes 2 No
		the Maryla 28a-f shor	ecto	MD BALTIM	ORE	Timonium	100	Citizen of What Country?
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	_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d.	Date signed (Month, Day, Year)
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	1	G		30. Name and address of person who co	empleted cause of death (Ita)	0/1-/-(
	5	Y		DR. TARIQ MAHMOO			UM, MD 2109	3
		Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign			

Physicia /Medic		1. Decedent's Name (First, Middle, Last	ottic Lo	ttie	Lev	vis				2. Date of De Month	Day	2004	3. Time of Dec	
Examin		4a. Facility Name (If northestitution, give street and number) Northwest Hospital				4b. City, Town, or Location of Death RANDALLSTOWN						BALT	unty of Death BALTIMORE	
uneral irector		5. Social Security Number 6. Se 212-12-5225 Usual Residence of Decedent	9X Y 7. Age	e (In yrs. Ia: 86	st birthday) Yrs.	Months D		Hours	Min.	8. Date of Bir 03/28/	1918	9. Bir	hplace (State or Fo	
show had a	lor	10a. State 10b. County MD BALTIMO	DRE	10c. City,	Town or Lo	cation ONSVIL	LE						10d. Inside City Li	
3a or 28a	I Director	10e. Street and Number 1202 REDCLIFFE R	et and Number O2 REDCLIFFE ROAD								10g. Citize	en of What Co	ountry?	
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DHMH 17 Rev 1/2001

Registrar

AUG 1 8 2004

			1 - State Amend Item 2	State of Ma 3a per Dr	aryland / Der •, G834,08	Partment of H	lealth an <i>Death</i>	d Mental Hy	giene Reg. No. 0	4 25819	
			1. Decedent's Name (First, Middle, Last)					2. Date of De	aath	3. Time of Death	_
П		Physician Dorothy Waterbury Moorhouse					July	22, Day 2004	5:10 A	И	
}	Examiner 4a. Facility Name (If not institution, give street and number)				4b. City, Town, o	r Location of D	eath				
п			336 West Edmonsto	n Drive		Rockvill	.e		Montg	omery	
	Funeral Director		323-32-1927	7. Ag	e (In yrs. last birthda) 84 Yrs.	Months Days	Hours N		3, 1919	9. Birthplace (State or Foreig Country) Washington, D	, C
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limit	s
	e Maryla	ctor	Maryland Montgome			1¥ Yes 2 □ N					
	3a or 26	by Funeral Director	10e. Street and Number 336 West Edmonstor	Drive		10f. Zip Code 20852			10g. Citizen of W USA	Vhat Country?	
36	d within 72 hours after death with the Maryland jene. Ir then "natural", or Hems 23a or 28e-f show I'the Medical Examine must be incittled at		11. Marital Status 1 Never Married 2 Married 3 V Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 1 1 If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cub	lispanic Origin' an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Blac	e-American Indian, k, White, etc. White	
Maryland 21215-0036	72 hour	Completed b	15. Decedent's Edu (Specify only highest grad	ation during most of	working		b. Kind of Business/Industry				
121	within in itene.	m m	Elementary/Secondary (0-12)	College (1-4or 5	1+)	e kind of work done DO NOT use retire arch Dire		•	Publish	daa	
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an	ld be ental ked o	To Be	Edward Martin Wate	rbury				May Rine		,	
ary	shou nd M mar	Ţ	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	ling Address (Street	and Number o	r Rural Route Numb	er, City or Town,	State, Zip Code)	
	es 1 and 2 should be filed of Health and Mental Hygis f item 27 is marked other r other traumalic event.		Gail Smith / daugh	ter	336	W. Edmons	ton Dr.	Rockvi11	e, Maryl	and 20852	
ore	of He of He fiter		20a. Method of Disposition 1 ☐ Burial 2 ※ Cremation 3 ☐ F	Removal from State	20b. Place of Dis	position (Name of ematory or other pla	ce) J	uly 23,	20c. Location -	City or Town, State	
Ĕ	Pag ment ant: f		'4 Donation 5 Other (Specify)			el Cremat		2004		, Maryland	
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Sor	w require been si should t				* "			-			
I Records,	e la has							24a. Was auto perfo	psy p ormed? d	Vere autopsy findings availabl rior to completion of cause of eath? □ Yes 2□ No	9
Vital	Physician: The this certificate ral director, pag		25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital: 1 Innation: 2 FB/Outcation: 2 F							
of\	Physic this c		1 ☐ Yes 2 XNo		e 5 🔀 Residence 6 🗆 Other (Specify) 8d. Describe how injury occurred						
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Division	Attending r death.	lcat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ini	urv - At home, farm.		163 2 110	28f. Location /	Street and Numbe	er or Rural Route Number,	-
Δ	after Direction by	edical Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier (Check only one) 1 X Certifying Phy 2 Medical Examination	cause(s) and mar date and place, a	nner as stated. nd due to the cause(s)						
	o the ithin o the omple	Me	29b. Signature and title of certifier	and manner st	1100.	29c. Licens	e number		29d. Date signed	(Month, Day, Year)	
	⊢ <i>s</i> ⊢ ŏ		DAM AM	(10)X	•	02	2629	G	July 22	2004	
	b		30. Name and address of person who c	ompleted cause of d	eath (Item 23a) (Typ		0011)		- u_j	,,	
_			Albert P. Galdi M.	D. 15225	Shady Gro		ckville	, MD 2085	0		
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registr	ar's Signature	parks					

CD		1_ State	d / Department of Health and Certificate of Death	Mental Hygiene
Physic		1. Decedent's Name (First, Middle, Last) Emest	moore	2. Date of Death Month Day Year AUGUST 15, 2004 5:18P.
/Med Exam Funera	iner	4a. Fecility Name (If not institution, give street and number) 535 N. BRICE STREET 5. Social Security Number 6. Sex 7. Age (In yrs.)	4b. City, Town, or Location of Dea BALTIMORE [agt birthday] If Under 1 Year If Under 24 Hi	ath 4c. County of Death NA S. Date of Birth 9. Birthplace (State or Foreign
Directo			79 Yrs. Months Days Hours Mit	may 5, 1925 HShVIIIe, N.C.
ind 21215-0036 be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23e or 28e-1 show event, the Medical Evanther must be routiled at	ai Director	MD N/A Ba 10e. Street and Number 535 N. Brice Street	Utimore 101. Zip Code 21233	1 1 Pres 2 □ No 10g. Citizen of What Country? USA
036 ours after deat ral', or Items 2	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Fes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
2 39	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of w Printer PrinteR	Printing Co.
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ore, Ma es 1 and 2 s of Health ar filem 27 is		Josephine L. moore	Place of Disposition (Name of pemetery, crematory or other place)	Balto. mo 21223 Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of Her Important: If item any injury or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any or other any o	X	1. Signature of Funeral Service License	22. Name and Address of Facility GARY P March Fur	0-04 Owing 9 Mills, MS 270 Fredhilton Pass neral Home Balto, MS 21229
icate be executed Table Project Physician and physician and physician and street project Proje		23a. Pahr Enist the disease, of complications that caused the death shock of heart failure. List only one cause on each line. Immediate cause (Final disease). Condition resulting in death) Sequentially list conditions. If any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	Arteriosclerotic Card	Onset and Death
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alle completely filled in by the fune	Certification:	4 Homicide building, etc. (Specif	ome, farm, street, factory, office (y)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
the Hosp thin 24 hor the Fune	Medicai			ce, and due to the cause(s) and manner as stated. courred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
Y 2 3 5 8		> Clayma melhell	<i>Mp</i> 0.C.M.E.	AUGUST 16,2004
	state	31. Date filed (Month, Day, Year) 32. Registrate Signa	111 Penn Street,	, Baltimore, Maryland 21201
S Regis		30. Name and address or person who completed cause of death (Item 31. Date filed (Month, Day, Year) AUG 1 8 2004 32. Registrar's Signa	n 23a) (Type, Print) 111 Penn Street,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:34 P August 12, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MHRYLALL 8. Date of Birth (Month, Day, Year) 1□M 2 F Days 216-16-2296 16-1919 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No DALTIMORE Keysville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Whixo Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ownhomo 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Shekuxaa brother 21030 Cockeys ille 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State UM ConcreteR 22. Name and Address 21. Signature of Funeral Service Licenses FacilitYORK RA ALTERNATIVES FUNGRAC + CKEMATIONCIR 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician /Medical

Physician

/Medical

Examiner

10a. State

Funeral

Director

or 28a-f shov

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is 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natural",

Pages 1 permit. Pages Department of Important: if it any injury or o

The law requires that the death certificate be executed

the attending physician

certificate has

this

After

after death Director: A I in by the fi

within 24 hours a To the Funeral L

funeral director,

filled in by

P.O. Box 68760.

Division of Vital Records,

Hospital or Attending Physician:

other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

JaHison,

Completed by Funeral Director

Be 2

Immediate Cause (Final

Examiner

disease or condition resulting in death) Due to (or as a cons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a gons Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: Hospital: 1 Tes Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 VNatural Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 29a. Certifier Medical

Month Day

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death? 2 17 No 1 Tyes 3 Probably 4 Unknown

24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2 PNo 1 Yes

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDON

31. Date filed (Month, Day, Year) State Registrar

(Check only one)

32. Registrar's Signature

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Martha Μ. Nutwe11 August 15 2004 0416 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb. 9, 19 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F Director 217-46-4250 90 Mary land Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10a. State 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avant. The Nedical Examinat must be notified at 1 ☐ Yes 2 🛣 No Director MD Anne Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5842 Rockhold Creek Road 20751 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. 12 should be filed within 7 h and Menta! Hygiene. 7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Andrew Manifold Charlotte Iva Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Is m any injury or other traum James E. Nutwell (Son) 5842 Rockhold Creek Road, Deale, MD 20751 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sherbert Cemetery 8-18-2004 4 ☐ Donation 5 ☐ Other (Specify) Deale, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or conditications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician tract Urinary /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760 certificate be Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred a Hospital or Attanding Pl 24 hours after death. a Funaral Diractor: After the Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely To tha 29b. Signature and title of certifical 29c. License number 29d. Date signed (Month, Day, Year) 024804 MUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annegel's sel 0 9011 Peterson MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 8 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Yeer М Stanton Tre Nea1 August 11 2004 1053 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Sex 1XXM 2□F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Vrs Director unknown 11, 2004 Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 No Anne Arundel **Annapolis** Direct 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? 36 Corn Hill Street 21401 USA Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1XXX Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No **Black** þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avant ORCS. Moatre Donnell Neal Lamorea Natalie Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lamorea Stanton (Mother) 36 Corn Hill Street, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Fyrral Service Al Ansee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. avi 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Extreme 3 min /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached Ó 9 Unknown 9 Unknown Records, P. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? 1 VYes 2 300 2 | No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No 2 1 patient 2 ☐ ER/Outpatient 3 DOA After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 🖼 atural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Diractor: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) August 11,2004 30. Name and address of person who completed cause of death from 23ar (Type, Print) Annapolis, Md. 21401 2001 Medical enry Subel 31. Date filed (Month, Day, Year) AUG 1 8 2004 32. A gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Chase Tre Nea1 August 2004 1118 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days 1**X** M 2 ☐ F Director Yrs. unknown August 11,2004 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director XXYes 2 □ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36 Corn Hill Street 21401 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after topartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or lies any injury or other traumatic event, the Medical Examinas Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moatre Donnell Neal Lamorea Natalie Stanton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lamorea Stanton (Mother) 36 Corn Hill Street, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 8/16/2004 Metro Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Hardesty Funeral Home P.A. Talhel 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** xtreme 2 min resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed burial-transit Due to (or as a consequence of) Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ю in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown yd bengis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ò 90 1 Yes 2. Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate Division of Vital 2 🗆 No 1 Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 😭 No 2 ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗌 No 2 Accident in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide pellil To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of 2001 Medical Annapolis, Md. 2144 Subel

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month,

32. Registrar's Signature

2004

AUG 18

				ryland / Depa	artment of Health and I rtificate of Death	•	ne
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) 1. AMES GEORE 4a. Fecility Name (If not institution, give street and number) HARBCR HOSPITAL	GE RI CENTER	AMPER 4b. City, Town, or Location of Death BALTIMER	August 1	Day Year 3. Time of Death 4: 29 P M 4c. County of Death N/A
	Funeral Director		190-28-2128	69 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye, Apr 9,	ar) 1935 9. Birthplace (State or Foreign Country) Pennsylvania
	death with the Maryland ms 23a or 28a-f show rroust be rediffed at	Director	Maryland N/A 10e. Street and Number	10c. City, Town or Lo Baltim	ore	100	10d. Inside City Limits 1 🛣 Yes 2 □ No Citizen of What Country?
	death with ms 23a or must be	Funeral D	111 East Barney 11. Marital Status 12. Was Decedent E		2123 Was Decedent of Hispanic Origin? (S	30	USA
9600	hours after o turel', or Iter	Ď	1 Never Married 2 Married 1 Married 1 Married 2 Married 1 Married	Corea	Nas Decedent of Hispanic Origin? (S) f Yes, specify Cuban, Mexican, Puerto		Black, White, etc. Specify: White
Maryland 21215-0036	t within 72 liene. r than "net	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5		lent's Usual Occupation kind of work done during most of wor DO NOT use retired) curity Guard	king 16b.	. Kind of Business/Industry GE Brandon Shores
ryland	should be filed and Mental Hyg marked other metic event,	To Be (17. Father's Name (First, Middle, Last) John Ramper, Jr		Ann Se	ne (First, Middle, Maid edlocko	
	s 1 and 2 should f Health and Men item 27 is marke other treumetic		19a. Informant's Name/Relationship (Type, Print) Nancy May Ramper (Wife) 20a. Method of Disposition	111	g Address (Street and Number or Ru East Barney St.,	Baltimore	, Md. 21230
Baltimore,	Page: ment or ent: If i		1 🖫 Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hil	11 Cemetery 8/1	7/04 Ba	ltimore, Maryland
Ba	permit. Depart Import any inj		21. Signature of Funeral Service Licensee Kevin E	l'i	Name and Address of Facility AcCully-Polyniak 130 E. Fort Ave.,	Funeral Ho Baltimore	me, Md. 21230
	Physician /Medical Examiner		23a. Rent1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) a	ð.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death Onset August
8760,	te be executed ysician and te burial-transit	Ical Ex	cause. Enter Underlying Cause (Disease or injury that initiated events	Consequence of): NARY consequence of): PHERAL	S SMALL B ARTERY DIS VASCULAR	WEL BASE DISBASI	5 YRS + 5 YRS +
P.O. Box 68	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	Petal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires that the been signed by the should be detach	ed by P	Part II. Other significant conditions contributing to death bu				o use contribute to the cause of death?
		Completed by	HYPERLIPIDEMIA			24a. Was an autopsy performed?	
of Vital	<u>></u>	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatien	t 2 ER/Outpatient	Out	me 5 Residence	6 ☐Other (Specify)
ion o	fune fune		27. Manner of Death 1 Natural 5 Pending (Month, Day) 2 Accident investigation	Year) 28b. Time of Injury		28d. Describe how inj	
Division	To the Hospitel or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injunbuilding, etc.	y - At home, farm, stre (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of and manner state	examination and/or inve	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
)	To the To the Comp	Σ	29b. Signature and title of certifier	13	29c. License number D2 \$485		ate signed (Month, Day, Year)
,	2×1		30. Name and addless of person who completed cause of de	ath (Item 23a) (Type, F		2. il as	1 0 100 5
	Sta Registr	re .	31. Date filed (Month, Day, Year) AIIG 1 8 2004 32, Registrar	's Signature	South	10174 114	· 11/25

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registra HTND TTFM 1. Decedent's Name (First, Middle,	#10a-f PER	laryland / Dep FH G834 ^C 8	Fificate of	Death		Reg. No. 0) 4	25826
	Physic /Med	ical	Donzie	Lee	Roberts	A.K.A.		2. Date of De Month August	13,2004		3. Time of Death 11:27a M
	Exami	ner	4a. Facility Name (If not institution, s 17906 Red Rock)	4b. City, Town, o	t Location of Death		4c. County Montg		
	Funeral Director		5. Social Security Number 6 408-22-1605		ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	25,1922	9. Birthpla Counti	ace (State or Foreign y) COW, TN
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	d. Inside City Limits
	e-fsh	ctor	-MD MI Montgo	mery WAYNE	- Cormant	ow n D	ETROIT				1 Pres 2 □ No
	ath with the 23a or 28	rai Dire	10e. Street and Number 13929 17906 Red Rock	9 ST. AUBIN Driv e	Γ	10f. Zip Code -20874	4821	2	10g. Citizen of V USA	Vhat Countr	y?
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural; or itams 23a or 28e-1 show other traumatic event, the Medical Examiner roust be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1	?	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blac Specify	e - America k, White, et Bla	tc.
21215-0036	within 72 hiene. Iene. r than "natu	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education grade completed) College (1-4or	(Give	dent's Usual Occup kind of work done o DO NOT use retired Laborer	ation during most of worki t)	ng	16b. Kind of Bu		,
Maryland 2	2 should be filed within ? n and Mental Hygiene. 'is marked other than " raumatic evant, the Med	To Be C	17. Father's Name (First, Middle, La Jesse Roberts	,			18. Mother's Name Bessie	(First, Middle,		9)	
-	and 2 sho ealth and ! n 27 is ma		19a. Informant's Name/Relationship Donna Taylor Day				and Number or Rura				ode)
Baltimore,	Page nent o		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of the C	ify)	20b. Place of Dispo cemetery, cres Lincoln Me	natory or other plac	August 2004		20c. Location - C Clinton To	-	
Ba	permit. Pa Departmer Importent any injury once.		21. Signature of Juneral Service Lic	33		TOUL Fast	L. Stevens	⊇ Balti	more Md.	Inc 21230)
	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to minus disease.	aDue to lor as			factures.		rest,	lr lr	pproximate nterval Between onset and Death
68760,	ilicate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	a consequence of):						
P.O. BOX 6	t the death cert by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h Da	ay Year
ecords, r	w requires tha been signed I should be det	by	Part II. Other significant conditions			derlying cause give	n in Part I.	23e. Did to	bacco use contrib es 2 No 3		cause of death? ly 4 □Unknown
		Completed	HyperKa	ion,	astro inte	stinal b	pleeding	24a. Was a autops perform	med? pri	ere autopsy or to compl ath? Yes 2	r findings available letion of cause of
ō	this ral dir	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	28a. Date of Injur		3□ DOA Othe	4 LI Nursing Hom	e 5 Reside		(Specify)	austes
DIVISION	is of Attanding residence is after death. In Director: After is at in by the funera	Certification;	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigativ 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	he -	ury - At home, farm, stre	M 1□Y	es 2 □ No	8f. Location (St City or Town	treet and Number n, State)	or Rural R	oute Number,
	within 24 hours after To the Funeral Directory completely filled in b	edical	29a. Certifier (Check only one) Certifying F	hysicien: To the best ominer: On the basis of and manner sta	of my knowledge, death examination and/or inv tted.	occurred at the time estigation, in my opi	e, date and place, ar inion, death occurre	nd due to the ca d at the time, d	ause(s) and manr ate and place, an	ner as state d due to the	ed. e cause(s)
	Con	M	29b. Signature and title of certifier	Ide	1 ma	29c. License	39501	2	9d. Date signed (v, Year)
	5		30. Name and address of person who	OLDER	mo.	Print)	onegate	Dr. S.	ilver Sy	rong	MD 1 Zogas
H	Sta Registr H 17 Rev 1/20	ar	31. Date filed (Month, Day, Year) AUG 1 8 20	A	ar's Signature	Sporter	8				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Year 740 AM illia 04 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death ISQA, A If Under 24 Hrs. - BELAIR TOM He9/14 01 ARINER If Under 1 Year 5. Social Security Number 7. Age (In yrs. Jest birthdey) Birthplace (State or Foreign Country) Months Days 1 M 2 F Hours 220-14-3485 Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street and Number 21014 USH 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status 2 Married 1 Never Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ₺ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tlorist esianer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Na e/Relationship (Type, Print) 3719 Rush Rd. JARRETTSVILLE MD 21084 20a. Method of Disposition 1 ☐ Burial 2 Di Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemeter) rematory or other place) Date 20c. Location - City or Town, State 8-16-04 FUNERALCHAPEL-FOREST HILL, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FOREST HILL, MD 21050. 23a. Pm11. Enter the diseal shock, or heart failure. EVANS FUNERALCHAPEL-BELAIR, BNEWPORT DE. Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Hemenhagee Immediate Cause 15-disease or condition resulting in death) day Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No TO Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner ata has bean signed by the attending physicien end page 2 should be datached for use as the buriel-transit Records, P.O. Box 68760 Physician/Medical After this certificata has of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifici completally filled in by the funeral director,

Division

Physician

/Medical

Examiner

10a. State

MD

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Director

by Funeral

Completed

Funeral

Director

2 should be filed within 72 hours after daath with the Maryland end Mental Hygiene. Is marked other than "natural", or Hema 23a or 28e-f ahow

permit. Peges 1 and 2 sh Department of Health end important: If Item 27 is m any Injury or other traum

Physician

/Medical

Examiner

Maryland 21215-0020

Baltimore,

Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at

ò Completed Be Certification: To

Medicai

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

(Check only one)

5 ☐ Pending investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier

29c. License number D0056607 29d. Date signed (Month, Dey, Year) 13th 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) NO 602. S. ATWOOD Rd BELATRAD 21014 井106 ANGELO JOSEPH

State Registra

31. Date filed (Month, Day, Year) AUG 1 8 2004 32. Registrar's Signature

		1	State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Certificate of Death Reg. No. 0 4 2	5828
	Physici		CLAUDE SWANSON STEWART Aug 15 2004 Year 1	3. Time of Death 10:15 A M
	/Medic Examin		4. County of Dooth	e1
1	Funeral Director		100 M 2 F	e (State or Foreign) inia
	aryland show d at	_	Tanahanan	. Inside City Limits 1 ☐ Yes 2√☐ No
	vith the Mi	Directo	10e. Street and Number 6305 Orchard Road 10f. Zip Code USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. It has the marked other than "neturel", or items 23a or 28e-f show other transmitted in the Maryland Examination and be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	
21215-0036	within 72 hoursene.	Completed b	Signature Specify only highest grade completed Specify only highest grade completed Specify only highest grade completed Insurance Auditor Insurance Auditor National Insurance Auditor National Insurance Auditor Insurance Auditor	fe
and 21	ould be filed w Mental Hygien tarked other th natic event, Ins	Be	18. Mother's Name (First, Middle, Last) Clarence Melvin Stewart Mary Esther Rainey	
Maryland	and 2 should leath and Men n 27 Is marke	2	19a. Informant's Name/Relationship (Type, Print) Claudette Gast (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co	
Baltimore,	0 0		20a. Method of Disposition 1 \(\mathbb{X}\) Burial 2 \(\subseteq \) Cremation 3 \(\subseteq \) Removal from State (a) \(\text{Specify} \) 3 \(\subseteq \) Cher (Specify) (b) Place of Disposition (Name of cometery, crematory or other place) (b) Place of Disposition (Name of cometery, crematory or other place) (c) Color (Signature of Color	
Balti	permit. Pag Department Importent: I any Injury o			1225–1856
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	pproximate terval Between nset and Beath
8760,	Examiner be executed buy sician and streep burial-transit	dlcal Examiner	Sequentially list conditions, if any, leading to immediate above. Enter the Joseph Sequence of Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Zneeh
O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ıy Year
rds, P.	quires that n signed by	by	Part II, Other significant conditions continuously to dealin but not resulting in the underlying cause given in rait i.	_,
Il Records,	The ate h page	Completed	24a. Was an autopsy performed? death? 1 Yes 2 No 1 Yes 2	findings available letion of cause of
of Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	
Division o	ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Homicide Accident building, etc. (Specify) 28a. Date of Injury 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28b. Time of Injury 4 Work? 1 Yes 2 No 28c. Injury 4 Work? 28d. Describe how injury occurred 28d.	oute Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the	e cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier Peterson usp 29c. License number 29d. Date signed (Month, Day 8/15/200	r, Year)
	\wedge		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature	

		•	1- For State of Maryla Registrar	•	artment of H			7 / / /	es.Tis	25829
	n Physici	an	Decedent's Name (First, Middle, Last) CNA DI EC. D. CNA DI	OMETAN	ITCE ID		2. Date of De Month		Year	3. Time of Death
	/Media	cal	CHARLES R 4a. Facility Name (If not institution, give street and number)	. STEIN	4b. City, Town, or	Logation of Do	Aug.	13, 2004		10:30 AM
	Examir	ner	GENESIS ELDERCARE - HOMEWOOD	CENTER	BALTI		4(1)	N/A	Death	
	Funeral Director		5. Social Security Number 218-60-4920 1 № M 2□ F 5.	rs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		th y, Year) , 1952	Coun	ace (State or Foreign try) yland
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County 10c. Maryland N/A	City, Town or Lo	cation Saltimore				10	0d. Inside City Limits
	th with the 23a or 28a sat be noti	Funeral Director	10e. Street and Number 6000 Bellona Avenu	ue	10f. Zip Code 2121	12		10g. Citizen of W	hat Coun	try?
920	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Itams 23a or 28a-f show avent, the Medical Ever ill servant be rediffed at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🏋 No	spanic Origin? n, Mexican, Put Specify:	(Specify Yes or No arto Rican, etc.)	- 14. Race Black Specify:	- America , White, e	etc.
21215-0036	filed within 72 ho Hygiene. ther then "natur ent, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	(Give	tent's Usual Occupa kind of work done d DO NOT use retired; Disabled	luring most of w)	vorking	16b. Kind of Bus		,
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) Charles R. Steinhice	, Sr.			ame <i>(First, Middle,</i> rley Anth)	
	s t and 2 should f Health and Men itam 27 is marke other traumetic		19a. Informant's Name/Relationship (Type, Print) Shirley L. Cosgrove (Mother		ng Address (Street a Belt St.	., Balt	Rural Route Numbe imore, Ma	er, City or Town, S ryland	itate, Zip 212	Code) 30
Baltimore,	000 -		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hi	natory or other place 11 Cemete	ry 8/	Date 16/2004	Baltime	-	wn, State Maryland
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee George M. F.		McCully- 130 E. F	Polynia ort Ave	k Funera	l Home,	P.A. 2 1 230)
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that daused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a constitution or condition or condition)	ration	er the mode of dying	, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 months
	Examiner	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	ronced	Ataxia	(Fr	ederick s			20+ Tra
68760,	icate be executed physician and the burial-transit	icai	that initiated events resulting in death) Last C. Due to (or as a cons	1 1						
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of preduction in the past 12 months? 4 ☐ Pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant at time of the preduction in the past 12 months are the pregnant at time of the preduction in the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the past 12 months are the preduction in the	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont		y Day Year
<u>α</u>	quires that en signed b tuld be deta	by	Part II. Other significant conditions contributing to death but not	resulting in the u	nderlying cause give	n in Part I.		obacco use contrib res 2 Mo 3		e cause of death?
Il Records,		Completed					24a. Was autop perfo 1 Yes	rmed? pri	or to com ath?	sy findings available pletion of cause of
Vital	Physician: this certifical	Be	25. Was case referred to medical examiner?		Othe		eath (Check only o			
of	ng fter ne	ation; To	1 Yes 2 No 10 Spiral 1 Inpatient 2 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of	28c. Injury Work	at ? 'es 2 □ No	Home 5 Resid	dence 6 ∐Other now injury occurred		
Division	F S F C	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, streecify)	eet, factory, office		28f. Location (5 City or Tox	Street and Number m, State)	or Rural	Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my light one in the best of my light one in the best of examiner: On the basis of examiner and manner stated.	knowledge, death ination and/or inv	estigation, in my op	inion, death oc	curred at the time, o	date and place, an	d due to	the cause(s)
	To To to com	Σ	29b. Signature and title of certifier Mian-O Krowy, mo		29c. License	1865		29d. Date signed (ay, Year)
γ,	J		3,001.00	tem 23a) (Type,	print)	altimo	ro mo	(212	0	
0	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signary AUG 1 8 2004	Janaturg A	pals					

			For State	1 lease			land / De		nt of H	lealth and M	lental Hy	giene	101.	25020
		3 k;	1. Decedent's Name (First Middle La	ast)				e or i	Dealli	2, Date of De	Reg. Ne.	104	3. Time of Death
	Physicia		James		Elmo		Spence	r			A Month	Day	9 Year	111:400
	/Medic Examin		4a. Fecility Name (If no				o penee		, Town, or	r Location of Death	region	4c. Cou	inty of Death	1.10
6.1	LAGIIIII	3	St. Agn	es Hos	pital			Ва	alti	more		N	/A	
	Funeral	- 1	5. Social Security Num	ber 6.	Sex		yrs. last birthda		r 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date 2-21		9. Birth	place (State or Foreign
	Director		230-42-59	903	X □M 2□F	70	Yrs				2-21-	34	Vir	ginia
	and w	-	Usual Residence of Di 10a. State 1	ob. County		100	c. City, Town or	Location						10d. Inside City Limits
	Maryl f sho	ō	Md.	N/A			Balti	more						1 X Yes 2 □ No
	death with the Maryland ms 23s or 28a-f show rmust be rodified at	Funeral Director	10e. Street and Numb						p Code			10g. Citizen	of What Cou	intry?
	th with	aiD	2909 Wi	nchest	er St.			2	2121	7		USA		
	ems	iner	11. Marital Status		12. Was Dec Armed F	edent Ever orces?	in U.S. 1	3. Was Dece	dent of H	ispanic Origin? (Sp. in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Ameri Black, White	
36	s afte	by Fu	1 ☐ Never Married 3 🔀 Widowed 4 I		If Yes, G			1 🗆 Yes	№ No	Specify:		Spe	ecity: Bla	ck
8	tural selection	ed b		5. Decedent's E	Year or [Jales.	16a. De	cedent's Usu	al Occupa	ation		16b. Kind o	l Business/Ir	ndustry
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pu	al Hy d oth	Be (17. Father's Name (Fig.	rst, Middle, Las	t)					18. Mother's Name		Maiden Sun	name)	
<u>ya</u>	2 should be filed within 72 hours after and Mental Hyglene. Is marked other than "naturat", or ite aumatic event, the Medical Exantret	2	Samuel		Spen	cer			1	Salli		pence		
Maryland 21215-0036	12 sh h and 7 is rr traurr		19a. Informant's Nam	·		+02			•	and Number or Run		•		· · · · · · · · · · · · · · · · · · ·
	of Health of Health Item 27 i		Annie \	Waters eition	Sis		0b. Place of Dis				Date TIMC		aryla on - City or T	nd 21215 own, State
je L	Pages nent of I ant: If its ary or o		Burial 2 0	Cremation 3	Removal from	i State				ery 8-19	0.04	Lanso	drown	o Md
Baltimore,	그는끝등	ĺ	21. Signature of Fune	ral Service Lice	ensee	117		22. Name ar	nd Addres	ss of Facility				e, mu.
ä	Departing Department on in once.		Lloyd	M. Es	tep			Estep I308 ^p	Euta	others I aw Place	Funera e Balt	l Ser imore	;Ma.	21217
			23a. Part1. Enter the shock, or heart f	disease, or con ailure. List only	nplications that	caused the each line.								Approximate Interval Between
	Pnysician		Immediate Cause (Findisease or condition	nal	. An	ovi	c. Ex	con	hal	stath	นร์			Onset and Death
	/Medical Examiner		resulting in death)		Oue to	(or as a co	nsequence of):		+	7 6				
Vd.		<u>_</u>	Samenially list condi	itions	b. Due to	Or as a co	nsequence of):	-1-10	aM	raku	MC_			reaso_
001	nsit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events	ing ury	Co	77.00	7 4 Dad	12	115	10,00	0 -1 1 1			tile as A
The ?	be executed ician and burial-transil	Exai	resulting in death) Las	st	c. Due to	(or as a co	nsequence of):	- <i></i>		J EVIL				July 3
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289	certifica oding ph use as th	Med	IF FEMALE:						-6	/				0
Hox No.	death ce e attendi ed for use	an/I	23b. Was decedent p			birth 2 🗌	Fetal death	3 ⊒Ectopic p					Date of deliv Month	ery Day Year
0	the a	Physician/Med	1 ☐ Yes 2 ☐ ħ		4□Preg 9□Unkr	nant at time nown	of death	5 🗌 Other (sp	oecify)					
0	sician: The law requires that the death certifica certificate has been signed by the attending phrector, page 2 should be detached for use as the	Ph	Part II. Other significa	ant conditions	contributing to o	death but no	ot resulting in the	underlying o	cause give	en in Part I.	23e. Did t	obacco use c	ontribute to t	the cause of death?
g, Sp	uires sign ld be	d by									1 🗆 '	Yes 2□No	3 ☐ Prof	bably 4 Unknown
Cord	s beer shou	Completed									24a. Was		b. Were auto	opsy lindings available
Rec	The la te has	ошо										rmed?	death?	ompletion of cause of
ita	ian: rtifica stor, p	BeC	25. Was case referred	to medical	C- E-					26. Place of Deat				
>>	S 50	To E	examiner?		Hospital:	Impatient	2 ER/Outpa		OA Othe	er: 4 🗌 Nursing Ho	me 5 Resid	dence 6 🗆	Other (Specia	(y)
Joseph Control		on:	27. Manner Leath 1 Leatural	5 Pending		of Injury oth, Day Ye	ar) 28b. Time Injur		28c. Injury Work		28d. Describe I	now injury oc	curred	
Signature Sign	ttend death stor: / the f	icat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not I	be an Die	e of Injune	At home, larm,	M street factor		Yes 2 □ No	28f Location (Street and Nu	mber or Run	al Route Number,
Divisi	l or A after Direc	Certification:	4 🗌 Homicide	determined		ding, etc. (S		Street, lactor	y, 011100		City or Tov	vn, State)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune									ne, date and place,				
	the He in 24 the Fu	ledicai	one)			nner stated.	C and/or			pinion, death occurr				
	To To	Σ	29b. Signature and titl	le of certifier	11	/	5	/	c. License			29d. Date sig	med (Month,	. 9 and
	/		00/0	0019	VIII)	100 04 4	(Itam 225) CT					1 maril	NIC	12001
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	Sta	te	31. Date liled (Month,		32.1	Registrar's	Signature	, /	20cKs	1 1				
	Registr	ar	IA	JG182	2004	Dener	1	PH.	l Kartis	32				
-	114147 0 4/04													

			For Stata Registrar	State of Ma	aryland		artmen rtificat			and M	ental Hy	giene	200	74	258	31
	Physici	an	Decedent's Name (First, Middle, Last								2. Date of De Month	Day		Year	3. Time of	
	/Medic Examir	cal	Robert T. Shaffe 4a. Facility Name (If not institution, give Saint Joseph I	street and number)	Cent	er	4b. City,	Town, or	Location o	of Death	AUGUS		-	of Death	12:25	5A M
	Funeral Director		219-30-5685	x 7. Age	e (In yrs. Ia 69	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 04/09/	rth ay, Year) 1935	r	Coul	place (State ontry) Virgi	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							1	I Od. Inside Cit	y Limits
	e Man	ctor	MD Baltimo	re	Ну	<i>r</i> des									1 🗌 Yes	2 X No
	with th	Funeral Olrector	10e. Street and Number				10f. Zip					10g. Citi:		/hat Cour	ntry?	
	eath v	eral	13827 Bottom Road	12. Was Decedent B	Ever in U.S	i. 13. V		082 tent of Hi	spanic Orio	in? (Spec	cify Yes or No		S.A.	- Americ	can Indian.	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show te Mudical Examirer must be notified at	b	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		l i	Yes, spec	ify Cubar	Specify:	, Puerto F	Rican, etc.)			k, White,	etc.	
15-0	be filed within 72 hours ttal Hygiene. d other than "natural", event, I're Medical Exa	Completed	15. Decedent's Edi (Specify only highest grad			16a. Deced		rk done d	urina most	of workin	g	16b. Kir	nd of Bus	siness/In	dustry	
212	l within liene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5	+)				rator	2		I	nsur	ance	Co.	
pu	be filed v tat Hygie d other t	BeC	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame	9)	· · · · · · · · · · · · · · · · · · ·	
yla		2	Robert T. Shaffer	<u> </u>							yersma					
Mar	2 0 0 0		19a. Informant's Name/Relationship (T) Marie O. Shaffe								Route Number				082	
re,	Hee Hee the		20a. Method of Disposition		20b. Pla	ice of Dispos	sition (Nan	ne of			ate .				own, State	
E I	Pages nent of h ant: If ite		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Bel	Air N	Memor.	ial	Gdn.	08/16	5/2004	Bel	. Aiı	r, Ma	arylan	f
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	assiln	(1					F. Las Kingsv				•	P.A. 087
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused ne cause on each lin	the death.	Do not ente	er the mod	e of dying	j, such as c	cardiac or	respiratory ar	rrest,			Approximate Interval Betw Onset and D	reen
	/Medical Examiner		resulting in death)	Due to (or as a		ence of):										
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8760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):										
9	entifica ling ph e as th	0	IF FEMALE:													
O. Box	that the death certific led by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1	2 ☐ Fetal d	leath 3 🗌	Ectopic pro					2	3d. Date Mont	of delive	•	ear
S, P	es that igned by be deta	by Ph	Part II. Other significant conditions co	ntributing to death bu	it not result	ing in the un	derlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contrib	bute to th	e cause of de	ath?
ords	en s		DIABETES MELLITUS	TYPE II					·····	_	1 🗆 Y	res 2	No 3	3 🗌 Prob	ably 4 ⊟Ui	nknown
I Record	The law ate has b page 2 s	Completed	RHEUMATOID ARTHRI	TIS						_	24a. Was autop perfor 1 Yes		pri de	or to cor	psy findings a npletion of ca 2/1 No	vailable use of
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:				Othe	r		(Check only o					
of	Phys or this oral di	7: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injun	y 2	R/Outpatient 8b. Time of		Bc. Injury	at Nur		e 5 Resid				")	
ion	Attending ir death. sctor: After by the fune	atlo	1 X Natural . 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М	Work′ 1 □ Y	? es 2 ☐ N	lo						
Division	Diste	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At hom . (Specify)	e, farm, stre	et, factory	, office		28	If. Location (S City or Tow		Number	r or Rura	Route Numb	er,
	the Hospitel in 24 hours a the Funerel ipletely filled	edical	one) 2 Madical Exami	sician: To the best o ner: On the basis of and manner stat	examinatio	edge, death in and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	l place, an occurred	f at the time, o	date and p	olace, an	nd due to	the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of cedifier	1	20.		29c.	License	number		1	29d. Date	signed	(Month, l	Day, Year)	
Ŷ	1				and the second	20) (7: -	D	37E	54			8	1,	-(04	
3			30. Name and address of person who co					7" ("11 17"	973k1 - 54	ers masses	Akim	····.	<i>i.</i>			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registra	r's Signatui		loon		uni ii	HHL AT	AND :	2122	<u></u>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year *Physician 3 29 PM Hazel Pearl Spamer 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN HOSPITAL IMORE BALT (n() OD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/24/1924 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🛣 F Director 80 213-20-2601 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No Director Baltimore Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9811 Oak Park Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status marked other than "natural", or Items imatic event, the Wedical Examination Black, White, etc. □Yes 2 XNo Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it and 2 should be fill Health and Mental H Be 2 Phillip Eck Pearl Shanklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health 8 ant: If item 27 Is ury or other tra 9811 Oak Park Drive - Baltimore, Maryland Stanley J. Spamer (son) laltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department o Important: If any injury or once. *4 □ Donation 5 □ Other (Specify) Rocky Rest Cemetery 08/17/2004 BAltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 11750 Belair Road - Kingsville, Maryland 21087 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner CPS1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ů 1 ☐ Yes 2 ☐ No this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOD

Registrar

State

SRILATHA

1

KANUMURU, 5601 LOCHRAVEN BLUD, BALTIMORE, MD-21239

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

			1 - For State Registrar	State of Maryland		nt of Health and	Mental Hygier	2001	25022
	Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last CO Aa. Facility Name (If not institution, give		SIMS	y, Towa, or Location of Dea	2. Date of Death Month	Day Year 14 2004	3. Time of Death
	Funeral Director	lei	5. Social Security Number 6. Sec	K MANDE	Care,	Typer If Under 24 Hrs	8. Date of Birth	9. Birthp	lace (State of Foreign try)
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Director	10a. State 10b. County	10c. City	Town or Location	Timere		1	0d. Inside City Limits
	death with ti ms 23a or 2 must be n	Funeral Dire	3817 DOLF	1E ID A VI	ENUE	ip Code 2 12 15 edent of Hispanic Origin? (5		Citizen of What Coun	A
5-0036	J within 72 hours after death with the Marylan Jiene. r than "natural", or items 23a or 28a-f show The Madical Examinat must be natified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	If Yes, sp 1 ☐ Yes		to Rican, etc.)	Black, White, e	
-61212	giene. grene. er than "nat	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	life. DO NOT	ork done during most of wa	rking 16b.	Kind of Business/Ind	,
yiand	be file	To Be (17 Father's Name (First, Middle, Last)	. SIMS		Lillia	me (First, Middle, Maide	n Sumame)	\supset
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aitimore	permit. Pages Department of Important: If it any injury or o		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licens	LO	UDON PI	CEME 08	-2004 N	1 Apy 1 A.	UD Home
	40 E 4 9		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	Te cause on each line.			c or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequent		LAR AC	(DEN	7	Onsol and Doalin
,00,	cate be executed physician and the burial-transit	ical Examiner	if any, leading to immediate cause. Enter University Cause (Disease or injury	Due to (or as a consequence Du					
O. Box of	death certifi e attending i id for use as	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3 ☐Ectopic p			23d. Date of deliver Month	y Day Year
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01 01	Physician: r this certific ral director,	To B	1 163 5 140		ER/Outpatient 3□ D	OA Other: 4 Sursing H	ith (Check only one)	6 ☐Other (Specify)	
loli o	ath. rr: After ne funera	ation:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	iry occurred	
DIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)			28f. Location (Street a. City or Town, State	e)	
	he Hosp in 24 hou he Fune pletely fi	edical	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, death occurred on and/or investigation	at the time, date and place n, in my opinion, death occu	, and due to the cause(s rred at the time, date an	i) and manner as stated place, and due to the following to the following	ted. he cause(s)
	Vith Com	Σ	29b. Signature and title of certifier	-B. C	en P	c. License number	29d. Da	ate signed Month, Di	ay, Year 0 +
0			30. Name and address of person who co	Port Heart	23a) (Type, Print)	Dieme	- Rol	Dine	L' , Hil
	Sta Registr	-	31. Date filed (Month, Day, Year) NIC 1 Q 2004	32, Registrar's Signatu	don	Nat		2	12/5

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	ertificate of I			200	14 25834
	Dhyaia	ion	1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	3. Time of Death
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	Funeral Director		220-22-1828	7. Age	e (In yrs. last birthday 94 Yrs.	Months Days	If Under 24 Hi Hours Mi		y, Year)	Birthplace (State or Foreign Country) VA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				40d Jacida Oir Livin
	Manyl f sho	5			,					10d. Inside City Limits 1 XYes 2 □ No
	the 28a	Jec.	MD NA 10e. Street and Number		BALT	IMORE 10f. Zip Code			10g. Citizen of W	
	3a or	ā	1103 WICKLOW ROAD				000			ŕ
	death ms 2	Jere	11.03 WICKLOW ROAD 11. Marital Status	12. Was Decedent B	ver in U.S. 13.	Was Decedent of Hi	229 Ispanic Origin? (Specify Yes or No-	US.	A e - American Indian.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exam as must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ ↑ If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Pue Specify:	orto Rican, etc.)		AFRICAN
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7	filed within 7 Hygiene. other than "r ent, the Med	npie	Elementary/Secondary (0-12)	College (1-4or 5-	life	kind of work done of DO NOT use retired	luring most of w	orking		,
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3	Mer Mer Marke Marke	²	ANANIS JOHNSON					IZA BOWLES		
Maryland	12 st hand 7 Is n traun		19a. Informant's Name/Relationship (T)	/pe, Print)		ing Address (Street a				State, Zip Code)
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altimore,	8°5' = 5		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		NEW CATHEDS	Matory or other place	ATIC:	Date 20, 2004	BALTON OF	City or Town, State
Bal	permit. Pa Departmer Important any Injury		21. Signature of Funeral Service Licens	88	2	2. Name and Addres	s of Facility W	ZLIE FUNERA	L HOME PA	
	002 e 0					638 N. GILM	OR STREET	BALTIMORE	, MD 2122	29
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		niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
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Вох	death certif e attending od for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{VNO} \) 9 \(\text{UNnown} \)	3c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
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5	,		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type,	Print)				(-)
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	Sta Registra	.6	29b. Signature and title of certifier Torrid 30. Name and address of person who co THOMAS S M (31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registrar	s Signature	pals				
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State of Manyland / Department of Health and Mental Hygiene

				State of M	iaryiand	/ Departme					Reg. No.2	04	25835
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			CROMWEN GENESIS	EldER CA	RE			BA	MAM	ne	/	1/a	
	Funeral		Social Security Number 6. Se	x 7. A	ge (In yrs. las	Month	ter 1 Year s Days	If Under Hours	24 Hrs. 8. Min.	. Date of Birth (Month, Day	Year)	9. Birthpl	ace (State or Foreign
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	pue 🛊	}	Usuel Residence of Decedent 10a. State 10b. County		10c. City. 7	Town or Location						10	Od. Inside City Limits
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20	ifter in the state of the state	y Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	? No		2 No		i, Puèrto Ric	ly Yes or No- can, etc.)		ck, White, e	etc.
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ore	ges 1 and 2 should t of Health and Mer If Item 27 is marks or other traumatic		20a. Method of Disposition 1 ✓ Burial 2 ☐ Cremation 3 ☐ F	amount from State		e of Disposition (A etery, crematory o	lame of r other pla	ce)		Date	20c. Location	City or Tov	vn, State
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Sio	tend Jeath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	20a Blace of In	ium. Athoma	M , farm, street, fact		Yes 2 □ i		Location (S	trant and Numb	or or Pum I	Route Number,
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	() J	-	30. Neme and eddress of person who co	mpleted cause of	death (Item 23	Se) (Type, Print)				4	1	/	
)		MANTHA C. RAUM	UNDO, n	10 56	01 ROCH	Raur	1 Oll	7 Ba	eltioner	/		
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Brian Wilkinson John August 15 2004 4:28 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Feb. 3, 1946 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1**X**☐M 2☐F Yrs 217-76-7626 58 United Kingdom Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if them 27 is marked other then "nature!" or hours any injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 📆 💢 o MD Director Anne Arundel Shady Side 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 4963 Dogwood Street 20764 Britain Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 TX Married 1 ☐ Yes 2XXNo Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic 12 Marine 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Morris Wilkinson Florence Easton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Diane F. Wilkinson (Wife) 4963 Dogwood Street, Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ACremation 3 Removal from State Metro Crematory 8-17-2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Lice 19 e 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 lyeu /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 autopsy performe 2 No 2.2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 1 npatient 2 No 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After ! Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ပ 15-2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson Robert MD 32. Registrar's Signature AUG 1 8 State Registrar

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryland		artment of F rtificate of		Re	eg. No. 0 0 4	25838
	Physici /Medic	_	1. Decedent's Name <i>(First, Middle, Las</i> Josefina	Q. Aleta				2. Date of Deat	Day Year	3. Time of Death 5 ! 20 A M
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			Crescent City Co		et hirthday)	Rive:	rdale If Under 24 Hrs	. 8 Date of Birth	Prince G	
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	or 24	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	Country?
	s 23a		3724 36th Stree	t 12. Was Decedent Ever in U.S	12.1	207		Consider Vac or No.	U.S.A.	percan Indian
36	be filed within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	y Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cub 1 ☐ Yes 28 No		Specify Yes or No- to Rican, etc.)	Black, Wh	
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	and 2 saith a n 27 is		Socorro L. Quino	ones - Sister	3724	36th St	reet Mt	Rainer	MD 20712	
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	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examination and manner stated.	viedge, deat on and/or in	h occurred at the ti vestigation, in my	me, date and plac opinion, death occ	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)
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0	23		30. Name and address of person who	, - 0	23а) (Туре,	Print) Ale	X conde	erda la	Z. 00K	0737.
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 7 2004	2. Registrar's Signati	ure for	K)				

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Box
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Records,
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Physicia /Medic		INET	ΓΕ	ANDERSON				July 3	30, 2004°	5:204 M
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OI VILA Physician: r this certific ral director,	To B		No	Hospital: 1 Alnpatie		int 3□ DOA Oth	ner: 4 Nursing Hor	ne 5 Resider	nce 6 Other (Spec	cify)
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To the Hospital or Attending Physician: White 24 hours after death after death To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only	Certifying Ph	ysician: To the best	of my knowledge, dea	th occurred at the time	me, date and place, a	and due to the car	use(s) and manner as te and place, and due	stated.
the Hin 24 the F	Medi	one) 29b. Signature and	\sim	and manner sta	ited.	29c. Licens			d. Date signed (Monti	
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Sta Registr		31. Date filed (Mo.	nth, Day, Year) G 0 3 200		ar's Signature	**				/
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requires that the death certificate be executed use as the burial-transit the attending physician Division of Vital Records, P.O. Box 68760, been this certificate funeral director, filled in by

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY 29, 2004 **Physician** 1:00 P M CARLTON W **ADAMS** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL PERRY POINT VA MARYLAND HEALTH CARE SYSTEM If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 € M 2 □ F Director 54 1949 Washington,DC 213-56-7338 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 28a-f show other traumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Director MD Prince George's N. Brentwood 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20722 U.S.A. "natural', or Items 23a 3918 Wallace Road death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X2 Yes 2 ☐ No Marines 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Black. 1 Yes 28 No Specify þ 3 ☐ Widowed 4x ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th Labor Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I Anna Brown Francis W. Adams 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . wyes 1 and 2
. Se artment of Health ar mportant: If itam 27 is any injury or Anna V. Adams/Mother 3918 Wallace Road N. Brentwood, Maryland 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/5/2004 Laurel, Maryland * 4 □ Donation 5 □ Other (Specify) Maryland National 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home K.D. 7474 Landover Road Landover, Maryland 20785 aroha 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC LUNG CANCER **Physician** 1 YEAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Hospital or Attanding Physician: 24 hours after death. Funaral Diractor: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No 10 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To tha Funaral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number arotine D15628 JULY 29,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAROLINA CUSTODIO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD, 21902 31. Date filed (Month, Day, Year) AUG 0 3 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of	Marylar		rtment of H		d Mental H	ygiene Reg. No./	2001	2581.1
-	- 100 - 100		Decedent's Name (First, Middle, Las	:t)					2. Date of D	Death	Vans	3. Time of Death
10	Physici /Medic		Mary Ethel Arnol	d					July	27	2004	11:02 P M
	Examin	10 Acres 10	4a. Facility Name (If not institution, give		ber)		4b. City, Town, or	r Location of D	eath	4c. (County of Death	
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altimore,		1 9	21. Sign unle of Funeral Service Leg	-	LV				sborne F			
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Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			-			2:	3d. Date of delive	iry
	death e atte	iciai	in the past 12 months?	4□Pregna	nth 2.⊞Fet antattime of∈		Ectopic pregnancy Other (specify) _	<u> </u>			Month	Day Year
о. О.	at the de by the a	hys	9 ☐ Unknown	9 Unkno	WN							
	res that igned t be det	by P	Part II. Other significant conditions of			-		en in Part I.				ne cause of death?
ord	w require been significant	ted	Appellena	augh	· ····	Dur	uan		- 10	JYes 2∟	No 3∐Prob	ably 4 ☐Unkn own
Vital Records,	e law r has be ge 2 sh	Completed	ortespororis						24a. We aut	opsy	prior to cor	psy findings available npletion of cause of
<u> </u>		Con							1 ☐ Yes	formed?	death? 1 ☐ Yes	2□ No
VII:	yeician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			• all post Oth	or	Death (Check only			
0	shys this al di	<u>و</u>	1 Yes 2 4-No 27. Manner of Death	28a. Date o	<u> </u>	28b. Time of	1 3L DOA	4 Littorsii	ng Home 5 ☐ Re 28d. Describ			()
L _O	ding After fune	tion	1 ☐Natural 5 ☐ Pending	(Month	n, Day Year)	Injury	Wor	k? Yes 2∐No	200. 5000115	o non injury	***************************************	
Division of		Certification:	3 Suicide 6 Could not b	e 28e. Place	of Injury - At h	nome, farm, str	eet, factory, office				Number or Rura	I Route Number,
á	al or At s after d il Direct d in by	erti	4 Homicide	buildin	ng, etc. <i>(Spec</i>	ry)			City or I	own, State)		
	ospita hours unera ly fille								lace, and due to th			
	To the Hospital or A within 24 hours after To the Funeral Dire- completely filled in by	ledical	(Check only 2 Medicel Examone)	and mann		ation and/or in			SCORINGO AL (ING IIM)			
	To t To t	Σ	29b. Signature and title of certifier	~~			29c. Licens	e number			signed (Month, i	
	h									700	-7 28.	2034
y	(7)		30. Name and address of person who	completed cause	e of death (Ite	m 23a) (Type,	Print)	MAG	ERSTO	Wod	mo a	21740
1		ate	31. Date filed (Month, 1997) 0	32. Pi	gistrar's Sign	ature	/ /					
	Regist		JUL 3'0 7	2004	areur	1. A	guli					

			For	State of Marylan	•	rtment of H		ntal Hygier	ne	
	DI		1 - State Registrer 1. Decedent's Name (First, Middle, Last	, ,		inicate of t		Reg. I Date of Death Month	2004	-8. Time of Deals.
f	Physici /Medic	al	4a. Facility Name (If not institution) of	+ B · H	DEL	4h City Town or	Location of Death	07/2	2 2004. 4c. Sounty of Death	7. PM M
	Examin	er	P-0B0X/7	35 Monto	elloA	re s-	lisbudy	MNZ	1801,4	2, Comico
	Funeral Director		5. Social Security Number 6. Se 15	7. Age (In yrs. 91		If Under 1 Year Months Days	If Under 24 Hrs. / 8 Hours Min.	Date of Birth (Month, Day, Yea July 22,	ar) 9. Birthol Coun 1913 TWO	ace (State or Foreign try) Rivers, WI
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	ation				Od. Inside City Limits
	ne Mary 8a-f eh	ctor	MD Wicomico) 5	Salisbu					1 ☐ Yes 2 No
	3a or 2	Funeral Director	10e. Street and Number 435 Monticello A	Ave.		10f. Zip Code 21801		10g.	Citizen of What Coun U.S.A.	· · ·
	er deatlitems 2	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Specif n, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - America Black, White, e	
9036	72 hours after death with the Maryland 'naturel', or items 23a or 23a-f ehow dical Exactiner rust be notitled at	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates:	1	☐ Yes 2💢 No	Specify:		Specify: Whi	te
215-(nin 72 h n natu	Completed	15. Decedent's Edu (Specify only highest grad	ie completed)	16a. Deced (Give life. D	ent's Usual Occupa kind of work done o OO NOT use retired,	ation furing most of working)	16b.	. Kind of Business/Ind	ustry
1212	iled with tygiene her tha	Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Hom	emaker	10 Mothada Nama //		Own Home	
land	uld be f dental F rrked ot tic ever	To Be	John	Hernday			18. Mother's Name (F		en Surname)	
Mary	d 2 sho th and ! 7 is me traume		19a. Informant's Name/Relationship (7) Bob Bohan - POA	rpe, Print)	19b. Mailin	g Address (Street a	ons Island	Rd. An	y or Town, State, Zip napolis, M	Code) D 21401
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or flems 23a or 28a-f ehow any injury or other traumatic event, the Modical Examinat must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	1 6	Place of Dispos	sition (Name of atory or other place	Date	-	Location - City or To	
Itim	artment prtant: injury c	- 1	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature	Chr			tery 07-27		cokeek, MD)
Ba	Depa Impo any is) ja	I got offen	101331		Huntt Fu P.O. Box	s of Facility neral Home 156, Wald	orf, MD	20604	
	District.		23a. Part . Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final	ications that caused the deat ne cause on each line.	h. Do not ente	r the mode of dying	g, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
ı	Physician /Medical Examiner		disease or condition resulting in death)	a. Due to lor as a conseq	uence of):	1 130	- 0		7	
	LAGITIMICI	ě	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	eme	(3 1)1	sease		(haary
	icate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):	sion				years
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Box 68	eath certifice attending pt for use as t	/Wed	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of deliver	v
о. В	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2 □ Fete 4□Pregnant at time of d 9□Unknown		Ectopic pregnancy Other (specify)				Day Year
s, P.O.	ss that the	by Ph	Part II. Other significant conditions con	ntributing to death but not res	ulting in the un	derlying cause give	on in Part I.	23e. Did tobacc	o use contribute to the	e cause of death?
ord	w require been slo should b		- Chromic	Lecubi Tho	Ma	er ov	" Kight		2) No 3 □ Proba	
Division of Vital Records,	The taw ate has bage 2 s	Completed	Pool					24a. Was an autopsy performed? 1 ☐ Yes 2 🔼	prior to com death?	sy findings available ipletion of cause of
Vita	siclan: The certificate irector, pag	o Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	55/0	3C DOA Othe	26. Place of Death (C	theck only one)		
n of	ng Phys fter this ineral dii	H.J	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 DOA 28c. Injury Work	at 28d	5 Residence . Describe how in		
/isio	I or Attending after death. Director: After I in by the funer	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, stre		res 2 □ No 28f.		and Number or Rural	Route Number,
ă	urs after oral Direc		4 nomicide	building, etc. (Specify				City or Town, Sta		
	To the Hospital or Atlending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Certifying Phy Description 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my op	e, date and place, and inion, death occurred	at the time, date a	(s) and manner as sta ind place, and due to	the cause(s)
)	To t To tl comp	Ž	29b. Signature and title of certifier	Mamil,	MD	29c. License	number	29d. [Date signed (Month, E	lay, Year)
	0.0	Ĥ	30. Name and address of person who co	1 -1 -	01	Print)	11 Rd #1	1011	bury M	071501
W	P 3	te	31. Date filed (Month, Play, Year)	32. Registrar's Signa	iture L	re 1514	T	1) >~~	3.07.0	1 4001
	Registr		JUL & 8 Z	1004 Jane	St K	perel.				

04-04996

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 17 per the 927 of 835 artment of Health and Mental Hygiene crn Unpend item Registrer #23,27,28a-f, per ME, G834,8/22/10/647ET of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ö1 **Physician** 2004 August 10:37 Alfonzo Alexander /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 2355 Franklin Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 20 F Months Days Hours Min. Yrs. Director 579 62 1979 June 19,1949 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits s 23e or 28e-f show ★□Yes 2□No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.
snt: If item 27 is marked other then "neturel", or Items 23e or: 1921 Cecil Avenue 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status treumetic event, the Medical Examiner of XYes 2□No If Yes, Give 1969-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Larry Alexander Ray Alexander Eva Mae Stradford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Nakia Hargrove/daughter 1131 K. Street SE Washinton DC 20003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 8-11-2004 | Cheltenham, Maryland 22. Name and Address of Facilit Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee CIBUCCETONIU Millely 4308 Suitland Road Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Narcotic Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1. Yes 2 \sum No 24a. Was an page 2 s 1 Xes Division of Vital 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Other (Specify) at SCENE 인 Yes 2 □ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of **Found** 28b. Tim **Found** 28c. Injury at Injury 28d. Describe how injury occurred Certification: After 1 Natural 08/01/2004 10:30 a^M 1 ☐ Yes 2 No death. 2 Accident investigation Unknown Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found at Residence 28f. Location (Street and Number or Rural Route Number, 4 | Homicide 2355 Franklin Street 24 hours a Baltimore, Maryland 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 The discretization and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 02, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U 111 Penn Street, Baltimore, Maryland 21201 4

31. Date filed (Month, Day, Year) AUG 1 0 2004

State

Registrar

			State of Maryland / Department of Health and	-	-	
		•	1 - State Registrar Certificate of Death		eg. No 2004	25866
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		Virginia Reed Adams	JULY	13 2001	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	ath	4c. County of Dea	
			Shady Grove Adventist Hospital Rockville 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Date of Birth	Montgome	
	Funeral Director		166-38-9868 1□ M 2월F 56 Yrs. Months Days Hours M	n. (Month, Day	, 1947 Per	rthplace (State or Foreign country) nnsylvania
	ow ow		10a. State 10b. County 10c. City, Town or Location		_	10d. Inside City Limits
	Many First	ţō	Maryland Montgomery Gaithersburg			XXYes 2 □ No
	or 28g	Director	10e. Street and Number 10f. Zip Code		log. Citizen of What C	country?
	23a	alc	404-D Blue Silk Lane 20879		U.S.A.	
	er deg	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
36	a within 72 hours after death with the Maryland Jiene. r than "natural", or Itema 23a or 28e-f show It e Macilcal Exactinational be notified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Year or Dates:		Specify: \[\bar{\cut}{\cut} \]	Vhite
o P	2 hou		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busines	s/Industry
215	thin 7 e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of will be DO NOT use retired)	vorking		
Maryland 21215-0036	70 70 10 10	Con	12 Retail Clerk		Retail	
<u>n</u>	D 14 D	Be		lame (First, Middle,		
3	2 should be and Mental Is marked o	ပ္	Earl Reed Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		Messen	
a Z	2 2 2 2		Robert Adams/ Son 5723 Courtney Drive,			20711
ē,	f Health item 27 other tra		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City o	r Town, State
Baltimore,	permit. Pages Department of H Important: If its any injury or of		1 □ Burial 2 ② Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) July	y 18,2004	Waldorf, N	Marvland
<u>=</u>	permit. DepartmImportal		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Robert E.		
<u> </u>	Depti Import		16000 Annapolis Ro	ad, Bowie	, Maryland	20715
ı			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	iac or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	. 12		1 041
		ē	Sequentially list conditions. b. CATROINTESTINAL BLEE	1119		10/9
	nted Insit	mine	cause. Enter Underlying Cause (Disease or injury			
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760,	w > w	cai	d			
9	The law requires that the death certificate b tite has been signed by the attending physic page 2 should be detached for use as the b	Physician/Med	IF FEMALE:			
Вох	ath ce ttendi or use	an/I	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	elivery Day Year
o.	at the dea by the a stached for	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)		10.0.1.	Duy Tou.
Ω_	that the ned by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Records,	w require been si should t	lete		24a. Was a	n 24b. Were a	utopsy findings available
Re	he lav e has age 2	ompleted		- autops perfor	sy prior to med? death?	completion of cause of
Vital		e C	25. Was case referred to medical 26. Place of F	1 ☐ Yes eath (Check only or	2No 1 Ye	s 2 No
\leq	> 0 0	0 8	examiner?		ence 6 Other (Sp.	ecify)
n of	ding Ph h. After th funeral	Ju: T	27. Manner of Death 12. Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Injury 28c. Injury 2	28d. Describe h	ow injury occurred	
Siol	Attending in death. ector: After by the fune	catic	2 Accident investigation M 1 Yes 2 No	_		
Division	or Attend after death Director: /	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S. City or Town	treet and Number or F n, State)	Rural Route Number,
	he Hospital or A n 24 hours after he Funeral Dire pletely filled in b		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ice and due to the	auso/s) and manner	hoteta a
	24 hc 24 hc Fun etely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of	curred at the time, d	late and place, and du	e to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Mor	th, Day, Year)
	> - 0		A. P. KURUVILLA, MD. Dittol8	2 1	TULY 13	, 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
			29b. Signature and title of certifier A. F. KURUVILLA, MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATIT P. KURUVILLA, III.25 ROCKVILLE PICE 31. Date filed (Month, Day, Year) JUL 1 9 2004	,#208	ROCKVILL	= , MO 2085
	Sta Registi		31. Date filed (Month, Day, Year) JUL 1 9 2004	,		
	negisti	ui	The same of the sa			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 12,2004 Physician 11:45PM ANTHONY JOSEPH ANASTASI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL CROWNSVILLE FAIRFIELD NUR. & REHAB CENTER Months Days Hours Min. APR 29, 1960 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** WASH., D.C. Months 1**∑**M 2□F 44 Yrs. 220-76-8764 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County rthan "natural", or items 23e or 28e-f shov The Motical Examiner must be nutified at 1 ☐ Yes 2 X No CROWNSVILLE MARYLAND ANNE ARUNDEL Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with U.S.A. 21032 1454 FAIRFIELD LOOP ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 X No Specify: WHITE Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) othar than ELECTRIC COMPANIES MASTER ELECTRICIAN 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Health and Mental Hitam 27 Is marked of rother traumatic aver Pages 1 and 2 should be MARIANNE JENKINS TONY ANASTASI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau once. 3174 GAINSBOROUGH CT. WALDORF, MD. 20602 SUSAN ANASTASI-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Cemetery, crematory of other place)

1 M Burial 2 Cremation 3 Removal from State
SACRED HEART CEMETERY 8-14-04 LA PLATA, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) MO0479 2. Name and Address of Facility RAYMOND FUNERAL 21. Signature of Fulleral Service Licensee SERVICE, P.A. PLATA, MARYLAND Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician FU1 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attanding Physician: The law requires that the death certificate be execu-Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2. No the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death After 5 Pending investigation 1-Natural after death. 1 ☐ Yes 2 ☐ No 2 / Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 05 WATER 31. Date filed (Month, Day, Year) State AUG 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 8 05**Physician** 5:20 Am 2004 IVA HINKLE ARNOLD /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) **Examiner** NORTHAMPTON MANOR HEALTH CARE FREDERICK FREDERICK B. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign JUNE 4, 1912 JENNINGSTON, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 235-40-6601 92 Director WVUsual Residence of Decedent filed within 72 hours efter death with the Marylend Hygiene. ther than "natural", or Items 23a or 28a-1 show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be notified at 1 X Yes 2 □ No TUCKER DAVIS WV Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? THOMAS AVE. 26260 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 <u>≥</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LORENZO DOW HINKLE CLARA ETTA LANTZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

JOANN PREGLEY/DAUGHTER 3363 STUART CT. ADAMSTOWN, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Buriat 2 Cremation 3 Removal from State DAVÍS CEMETERY 8-7-04 DAVIS, WV 4 ☐ Donation 5 ☐ Other (Specify) 22HINKLE FUNERAL HOME 21. Signature of Funeral Service Licenses PO BOX 186, DAVIS WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Hours **Examiner** Examiner nding physician and use as the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events vacheostm the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in death) Last 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 No 3 | Probably 4 | Unknown Stroke þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed 1 □ Yes 2 □ No ai or Attending Physician: Ti s efter death. Il Director: After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D4309 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 801 ZAID1 MAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2004 Registrar

DHMH 16 Rev 6/95

			1- For State of Maryland / De Registrer	epartment of Certificate of			ene 3. No.2 0 0 1	25847
	0,		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Yea	3. Time of Death
	Physici /Medio		Phyllis Marie Bergmann			July 22,		10:02 p ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town,	or Location of Death		4c. County of De	eath
			Holy Cross Hospital		r Spring		Montgo	nery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days		8. Date of Birth (Month, Day,) March 21,	(ear) 9. E	Birthplace (State or Foreign Country)
	Director		227-34-10/1	s.		March 21,	1929 Vi	irginia
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			 	10d. Inside City Limits
	f sho	ō	Maryland Montgomery Silver	r Spring				1 X Yes 2 ☐ No
	28a	rect	10e. Street and Number	10f. Zip Code		100	g. Citizen of What	Country?
	3a or	Ö	321 University Blvd. West, Apt. 203		901		U.S.A.	,
	ms 2	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cut		pecify Yes or No-	14. Race - A	merican Indian,
9	or ite	교	Amed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No			Rican, etc.)	Black, W	hite, etc.
03	ral', c	1 by	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates:	1□Yes 2₺ No	Specify:		Specify:	White
5	72 h	Completed by	(Specify only highest grade completed)	ecedent's Usual Occu Give kind of work done	e durina most of won	king 16	b. Kind of Busine	ss/Industry
121	han hen	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retire	ed)			
2	filed within 72 hours after death with the Maryland Hygliene. thar than "natural", or Items 23a or 28a-f show that the Middeal Examiner must be motified at		10 Dry 17. Father's Name (First, Middle, Last)	Cleaner	19 Mother's Nor	e (First, Middle, Ma		s Laundry
and	ad of	Be					uden Sumame)	
2	2 should be filed withlr and Mental Hygiene. is markad othar than raumatic avant, the M	²	James Paul Allen 19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Stree		Whetzel	Situ of Town State	Zin Codal
Maryland 21215-0036	id 2 s tth an 27 is trau		The state of the s	526 Orienta				
9	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. itam 27 is markad othar than "natural", or items 23a or 28a-1 show itam 27 is markad othar than "natural", or items 23a or 28a-1 show othar traumatic avant, the Medical Excipting results the resilied at		20a. Method of Disposition 20b. Place of D	Disposition (Name of			c. Location - City	
Baltimore,	0 0			crematory or other pla incoln Ceme		6/2004 B	centwood	Maryland
alt:	permit. Pag Department Important: I any injury conce.		21. Signature of Funeral Service Licensee	22. Name and Addr	ress of Facility Gas	ch's Fune	ral Home	P.A.
ä	Per Per Per Per Per Per Per Per Per Per		Claudatte Darch Samina		timore Ave			
	k		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dy	ring, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or contillor a D. Lateral Cardi	Ommonathy				Onset and Death Years
	/Medical		resulting in death) Due to (or as a consequence of					Icais
4	Examiner		Sequentially list conditions, b. Severely Depress	ed Left V ϵ	enticular	Function		Years
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
_	and and II-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Congestive Heart Due to (or as a consequence of					Years
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E						
687	fficate g phys	edic	d					
Вох	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of d	delivery
	death e atte	icla	in the past 12 months? 1 Yes 2 No 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	cy 		Month	Day Year
P.0	at the de by the a tached	Physician/Med	9 ☐ Unknown					
	es that igned b	by F	Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause gi	iven in Part I.			to the cause of death?
ord	w requir been si should	ted	Hypertension			1 Tes	2 X No 3 □	Probably 4 Unknown
Records,	e law r has be je 2 sh	Completed				24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
H		Con				performe 1 ☐ Yes 2		
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	ling After une	tlon	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury 1 Natural 1 N	ury Wo	ork? Yes 2 No	200. Describe now	injury occurred	
Division	f or Attendii after death. Director: A d in by the fu	fica	3 Suicide 6 Could not be			28f. Location (Street	et and Number or i	Rural Route Number,
Di	Dir	Certification;	4 Homicide Duilding, etc. (Specify)			City or Town,	State)	
	Hospital		29a. Certifier (Check only (Ch	death occurred at the t	ime, date and place,	and due to the caus	se(s) and manner	as stated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	and manner stated.					
	To To	4	29b. Signature and title of certifier		nse number	29d	Date signed Mo	nth, Day, Year)
_	0 3				-808		1 - 1/0	1
C	1(5)		30 Name and address of person who completed cause of death (Item 23a) (Tr	ype, Print) 3,3 Gea	rgia Ar	1.2 91	ver Jon	us Mel
	Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signature		1.7 70			7
*	Registr		JUL 2 6 2004 State 1. 6	ade				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month July **Physician** St.John Blanchard, 2004 11:35A M William Jr. /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Anne Arundel 15 N. Carol Street Laurel 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Wash., D.C. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Days Min. Months Hours 577-07-8253 90 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 te marked other then "natural", or Iteme 23a or 28e-f ehow ury or other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MDAnne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ν. Carol Street 20724 15 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Admin. -Sales Glass Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Marian Simonds William St.John Blanchard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 Pearl Ave. Sally A. Moore / daughter Crofton, MD. 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or Metropolitan Crem. 7-26-2004 Alexandria, VA. * 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, 20715 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONON **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐Unknown page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) certificate 1 Yes ₹ No Fo the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the hours after deat 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Illed in by 4 Homicide within 24 hours a 1 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D13339 7/26/04 8824 Ccenninghan Dr. Beruga the glits MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chan Chien 31. Date filed (Month, Day, Year) 82. Registrar's Signature State 2 2004 7 Registrar

Physici /Medic Examin	an		t)					2. Date of				3. Time of Death =
		James Barre	tt					Month 07		ау 6	Yeer 04	6:40A M
LAGITIE		4a. Facility Name (If not institution, give			4b. City,	Town, or	Location of D	eath		c. County of		07 1011
		St. Thomas More 1					7ille				ce G	eorge's
Funeral Director		5. Social Security Number 6. Se 137-30-2952	ZIM 2DE	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of (Month,	Birth Day, Year 2 22	r)	Coun	lace (State or Foreign try)
		Usual Residence of Decedent	81	113.				12 2	2 22		Farm	ville, NC
natural', or Items 23a or 28a-f show Iteal Examiner must be natified at		10a. State 10b. County		City, Town or Lo							11	0d. Inside City Limits
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or 20	Dire	10e. Street and Number			10f. Zip	Code			10g. C	itizen of W	hat Coun	try?
23	ra	630 Sheridan Stre				783				USA		
E a	nu	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced f Yes, spec	ent of Hi	spanic Origin n, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No-	14. Race Black	- America , White, e	
o'le	by F	3 Widowed 4 Divorced	1 ∐ Yes 2 [∏ No If Yes, Give Year or Dates:		1 ☐ Yes 2	2 ▼No	Specify:			Specify:	B1ac	ek.
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Il Hygiene. other tha	Con	12th		Mai	ntenai	nce			Geo	rgeto	wn U	<u> Iniversity</u>
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is marked of	^L	James Barrett						a Vines				
f Health and Meritem 27 is marke other traumatic		19a. Informant's Name/Relationship (T) Dorothy Clark/Sist						Rural Route Nun				
Health tem 27 i		20a. Method of Disposition) Hyatts	-			
0 - 1		1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Idinoval Irom Ctate	Place of Dispo						ocation - C		
Department Important: If any injury or once.	1 2	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens		Glenwood				23 - 04 arsha11's	Was	hingt	on,	D.C.
Depa Impo any ir		10 0 mais	8.00					Washing				
		23a. Part I Enter the disease, or complishock, or heart failure. List only or	ications that caused the de							р.с.		Approximate
	al Examiner	C squeritally list cunditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.									
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gned be det	by P	Part II. Dther significant conditions cor			derlying car	use giver	in Part I.	23e. Did	tobacco	use contrib	ute to the	cause of death?
been sign should be	ted	Cerebial	Intauch	on				1 [Yes 2	□ No 3	Probab	bly 4 Unknown
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recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:	Tena	-	4.1.		eath (Check only				
er this	. To	27. Manney of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of		c. Injury a	4 Let Nursing	Home 5 Res			(Specify)	
the fun	ig l	1	(Month, Day Year)	Injury	м	Work?	es 2∐No	204. 20001120	now inqui	y occurred		
To the Funeral Director: After th con pletely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre	et, factory,	office		28f. Location City or To	(Street an own, State	d Number	or Rural F	Route Number,
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To	2	29b. Signature and title of certifier	1. 2.	, () 29c.	License i		ALDER-		e signed (/		
ij	Ĺ	Vanller	new ore	Lud		ソン	185	2 (Hyal	JUL	4 22	20	OCH
		30. Name and address of person who co	mnleted cause of death (Ite	m 23a) (Type B	Print)							

			1 - For State Registrar	State of Mary			nt of He			Reg. No.) n n i .	25850
	Physici /Medic		1. Decedent's Name (First, Middle, L Alice L. T	3rooks					2. Date of D Month	Day Z4	Year Zooh)	3.45 PM
15	Examin Funeral		5. Social Security Number 6.	Adventst H	ospital yrs. last birthday, Yrs.	Ta	Kom r 1 Year	Location of De Q Pat If Under 24 H Hours M	drs. 8. Date of B	irth Day, Year)	9. Birthr	
	Director		219-34-7561 Usuel Residence of Decedent 10a. State 10b. County		c. City, Town or L	ocation			2/4/3	88		hellville, M
	Ba-f sho	ector		George's			Lando	ver		10 00		XXYes 2 □ No
	with the or 2	Dir	10e. Street and Number 7017 E. Fore	st Rd		10t. Zi	p Code	20785	5		izen of What Coui	ntry r
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show ship injury or other treumatic event, it is Modical Examinational Enrifited at ODEs.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Dece if Yes, spe 1 \(\text{Yes}			(Specify Yes or Nerto Rican, etc.)		14. Race - Americ Black, White,	
21215-0036	thin 72 ho e. en *natur M.vicel	Completed	15. Decedent's (Specify only highest g		(Give	s kind of w	ual Occupa ork done di use retired)	uring most of t	working	16b. Ki	ind of Business/In	dustry
	ygien ygien yer th		12th		P.G.	.co.		l Teacl			ducation	
and	ntal H ed oth	Be	17. Father's Name (First, Middle, La: Richard Proctor	st)					Name (First, Middl B. Yates	e, Maiden	Sumame)	
Maryland	12 should h and Me 7 is mark treumation	P	19a. Informant's Name/Relationship Mary Alice Brook			-		nd Number or	Rural Route Num.		r Town, State, Zip 20785	Code)
	1 and 1 Healt		20a. Method of Disposition	2	20b. Place of Disp	osition (Na	me of		Date	-	ocation - City or To	own, State
Ë	Pages nent of int: If i		ty Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spec	☐Removal from State	Maryland				/30/04	Chel	tenham,	Md.
Baltimore,	permit. Departn Imports eny inju		21. Signature of Funeral Service Lic	W. Q		H.S.W	ashin	gton &	Sons Co.	,Inc Wash	.D.C. 2	0019
80,	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the ty one cause on each line. a. Due to (or as a co	ialsch	er the mo	de of dying	Hea	diac or respiratory	arrest,	ise	Approximate Interval Between Onset and Death
8760,	ite be executed sysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	,							
.O. Box 68	the death certifical / the attending phy ched for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic (23d. Date of delive Month	ery Day Year
s, P	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying	cause give	n in Part I.			use contribute to ti □No 3□Prob	he cause of death?
I Record	The lasate has	Completed								opsy formed?	prior to co death?	ppsy findings available impletion of cause of
Vital	Physicien: The this certificate ral director, pag	Be c	25. Was case reterred to medical examiner?	Hospital:	2 ☐ ER/Outpatie	a alcare	Othe	r	Death (Check only		0 Floring (Cons.)	
of	ding After fune	tion: To	1 Yes 22 No 27. Manner of Death 1 Actural 5 Pending investigat	28a. Date of Injury (Month, Day Ye	28b. Time		28c. injury Work	4 🗆 IAUIZIII	g Home 5 Res 28d. Describe			y)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the fune	ertification:	2 Accident investigation of Could not determine	be 28e Place of Injury	- At home, farm, si Specify)	treet, facto	ry, office			(Street an own, State	d Number or Rura)	al Route Number.
	e Hospitel or 124 hours afte Funerel Dir letely filled in	Medical C	29a. Certifier (Check only one) Certifying 2 Medicel Ex	Physicien: To the best of meminer: On the basis of example and manner stated	amination and/or in	th occurre nvestigation	d at the tim	e, date and plainion, death o	ace, and due to the	e cause(s) , date and	and manner as s place, and due to	tated. the cause(s)
•	To the within 2. To the I complet	Me	29b. Signature and little of certifie				c. License	number	8		te signed (Month,	3
	CR4		30. Name and address of person when Ross St		h (Item 23a) (Type	, Print)	ingto	nl	ventist	HOSF	ital Ta	thoma Rait
	Sta Regist		31. Date filed (Month, Day, Year)	2. Registrar's		K				V		

		•	for State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of L		, ,	iene _{sg. No.} 2004	25851
	Dhysisi		1. Decedent's Name (First, Middle, L	ast)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physici /Medic		LAZINA	ALI	BOODH	OOSINGH		JULY 26		04:01 A ^M
<i>\</i>	Examin	er	4a. Facility Name (If not institution, ga				Location of Death		4c. County of Death	
			14500 DORSEY MIL			GLENWOOD If Under 1 Year	If Under 24 Hrs.	1 0 D / D: //	HOWARD	
	Funeral Director		5. Social Security Number 6. 578-42-6520 Usual Residence of Decedent	ALTHA OFF	81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV 5,		place (State or Foreign ntry) NIDAD
	/land		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Man a-f sh	to	MD HOWARD		GLENWOOD					1 ☐ Yes 2 ☐ No
	n with the	Funeral Director	10e. Street and Number 14500 DORSEY MIL	L ROAD		10f. Zip Code 21738			og. Citizen of What Cou	ntry?
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp		14. Race - Amer	
21215-0036	d within 72 hours after death with the Maryland jiene. I than "natural", or Itams 23a or 28a-f show I the Madical Examinar must be notified at	Þ	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	No i	1 ☐ Yes 2 🕅 No	Specify:	rucari, etc.)	Specify: ASI	
5-0	72 h natu	Completed	15. Decedent's 1 (Specify only highest g	Education rade completed)	(Give	dent's Usual Occupa kind of work done o	lurina most of work	ing	16b. Kind of Business/la	ndustry
121	within iene. than "	Idu	Elementary/Secondary (0-12)	College (1-4or	5+)	DO NOT use retired)		CELE ENDLO	VED
	filed within 1 Hygiene. othar than ant, the M		17. Father's Name (First, Middle, Las	st)	SEAI	MTRESS	18. Mother's Name	a (First Middle A	SELF EMPLO	YED
and	9 6 5 5 V	Be C	HYATT ALI	,			RAHEEMAN		aldon ournamo,	
Maryland	& PEE	၉	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street a			City or Town, State, Zi	Code)
	nd 2 alth a 27 Is r tra		YASMIN S. BOODHO	OSINGH - D					OD, MARYLA	
Baltimore,	es 1 and of Healt fitam 2 r othar		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date 2	20c. Location - City or T	own, State
E			1 Burial 2 Cremation 3 Cremation 3 Condition 3 Condition 3		PARK	MEMORIAL	07-2	7-04 F	ALLS CHURC	H. VIRGINIA
alti	permit. Pag Department Important: I any injury o	1	Sign tay of America Service Tid	ens e		2. Name and Addres			NERAL HOME	. Tanganan
<u> </u>	82 5 5		Martale	Jan Salar	7.	482 LEE H	IGHWAY, F	ALLS CHU	RCH, VIRGI	NIA 22042
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that caused y one cause on each li	d the death. Do not en ne.	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
2	Physician	22	Immediate Cause (Final disease or condition	Endor	A laintan	1 ginosta	amous Co	TETALMA	OI 92ml2	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	0				
1		<u>.</u>	Sequentially list conditions,	b. Due to lor as	a consequence of					
	ted nsit	Examlner	Cause (Disease or injury	1300 10 42 13	a consequences on					
	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760,	sicia buri	cal E		. d						
9	ificate g physi as the l									
Вох	leath certifica attending ph I for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deliv	ery
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes → No	4☐Pregnant a		Other (specify)			Month	Day Year
P.0	at the de I by the stached	Phy	9 🗆 Unknown 🍍							
	res tha igned l be det	þ	Part II. Other significant conditions	contributing to death b	out not resulting in the u	inderlying cause give	on in Part I.		acco use contribute to t	
orc	w requir been si should I	Completed						1 1 1 4 0	s 2 No 3 Prol	pably 4 AUnknown
ec	e law has b	nple	Anorthic -	CUCHUXIC	\			24a. Was ar autopsy	prior to co	ppsy findings available mpletion of cause of
<u>=</u>	: The licate har, page							perform 1 ☐ Yes 2	No 1 ☐ Yes	2□ No
VIE	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death	1.		
o	Phys r this ral di	2	1 Yes 2 No	1 inpatie		nt 3 DOA	4 LI Nursing Ho	me 5 X Reside 28d. Des ribe ho	nce 6 Other (Special winjury occurred	y)
on	ding F th. After funera	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da	y Year) Injury	of 28c. Injury Work	(? /es 2 □ No		,,	
Division of Vital Records,	if or Attandi after death. Diractor: A d in by the fu	Certification:	3 Suicide 6 Could not determine	d 280. Place of in	ury - At home, farm, st	reet, factory, office	-	28f. Location (Str	eet and Number or Run	al Route Number,
Ö	s afte	Cert	4 E Homicide	building, et	c. (Specify)			City or Town,	Siale)	
	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Medical (29a. Certifier 1 Certifying F 2 Medical Example 1	Physicien: To the best aminer: On the basis o and manner st	f examination and/or in	th occurred at the time operation, in my operation, in my operation.	e, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as s te and place, and due t	tated. o the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier	()	1	29c. License		29	d. Date signed (Month,	Day, Year)
	_		Jon 1/2.	Mh	1 KID	D	30573		4-29-04	
Λ			4							
	R (5)		30. Name and address of person who	completed cause of c	leath (Item 23a) (Type,	Print)	warn't Po	7= Kwall.	Columbia	Mp

1 - For State Registrar

Physic /Med		Rosetta M. E	Bowman		•		AUQUE	+ Day 3.	2004 3:15pm
Exam		4a. Facility Name (If not institution, give s	treet and number) du Nursina	Hom	l Boon	Location of Death	0	Wat	shington
Funera Directo		5. Social Security Number 6. Sex 217-80-8114	7. Age (In yrs.) M 2XIF 90	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day June 27		9. Birthplage (State or Foreign County) Mary land
death with the Maryland ms 23e or 28e-f show	octor	10a. State 10b. County Maryland Washingto		, Town or Lo	- g				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with th	Funeral Director	10e. Street and Number 22307 Pondsville Ro			10f. Zip Code 21783			10g. Citizen of USA	What Country?
eath v	erai		2. Was Decedent Ever in U.S	S 13 V			acify Yes or No-		ice - American Indian.
2-UU30 72 hours atter d natural; or Iten	b	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba I □ Yes 2√ No	ispanic Origin? (Spi in, Mexican, Puerto Specify:	Rican, etc.)	1	ack, White, etc.
	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. L	DO NOT use retired	during most of work	ing		Business/Industry
d Z 1 Z 1 filed within Hygiene. sther than	Cou	8		House	ewife			Home	
d be fill antal H ced oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			me)
hould d Mer marke	ို	Jesse J. Kendall 19a. Informant's Name/Relationship (Type	na Print)	19h Mailin	n Address (Street	Amanda S			State Zin Code)
Man d 2 sl th an th an traur		Eugene R. Bowman/S				ock Drive			
Heal Heal tem 2		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of natory or other place	1 1	Date		- City or Town, State
Saltimor Dermit. Pages Department of Importent: If It		1 X Burial 2 ☐ Cremation 3 ☐ Re 1	emoval from State		g Cemeter	1	2004	Smithe	burg,Maryland
inju	ė	21. Signature of Funeral Service License			. Name and Addres		Commence of the second		Home, P.A.
Deg de de de de de de de de de de de de de	1	Vin A.C.	Sle	42	25 S.Cono				sport,MD 21795
Physiciar /Medica Examine		23a. Part1. Enter the disease, or complic shock, or he if failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death e cause on each line. Due to (or as a consequence)	Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory are		Approximate Interval Between Ouset and Death
. BOX 68/6U, death certificate be executed e attending physician and id ror use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	=======================================	Can	<i>α</i> . γ			
S at at Sol	Physician/Medical	in the past 12 months?	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)				ate of delivery onth Day Year
ords, P.C. I requires that the de seen signed by the a	þ	Part II. Other significant conditions con	tributing to death but not resu	ilting in the ur	nderlying cause give	en in Part I.		bacco use con es 2□No	atribute to the cause of death? 3 □ Probably 4 ⊠Çinknown
HeC The law te has b	Completed						24a. Was a autop: perfor	sy	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
VITAL IN INCIDENT THE CONTINUATE THE	Be	25. Was case referred to medical examiner?				26. Place of Death		/	
Of VIta Physicien: r this certific ral director,	2	1 Yes 25 No	ospital: 1 ☐ Inpatient 2 ☐ £			4 DE-Nursing Ho			
	Certification:	27. Manner of Death Natural 5 Pending a Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □	k? Yes 2 □ No	28d. Describe h		
E Sign	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rural Route Number,
To the Hospital within 24 hours a To the Funerel t	Medical	29a. Certifier Check only one) Certifying Physical Examination (Check only one)	ician: To the best of my know ler: On the basis of examinat and manner stated.	wledge, death ion and/or inv	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the d ed at the time, d	ause(s) and m late and place,	anner as stated. , and due to the cause(s)
To t To t	Σ	29b. Signature and title of certifier		>	29c. License	323	2	29d. Date signe	ed (Month, Day, Year)
3H-2		30. Name and address of person who co		23a) (Type,	Print)		11		201 2
	State	31. Date filed (Month Agan Year) 5 20	32. Registrar's Signat	d (o	opal (Court	Hage	rs tou	on, Md. 21740
Regis		NUG U 5 20	JUA Jacem	B. B	cele				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Nancy Kinsman Burkhard 1, 2004 August 2:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Buckingham's Choice Healthcare Center Adamstown Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🛱 F 4, 82 Director 017-22-1108 Jan. 1922 Massachusetts Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2XNo Director Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WIT 3200 Baker Circle, Apt. I-107 21710 United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hygiene. ?7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Schoolteacher Special Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Kinsman Jessie Sinnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun <u>once.</u> Thomas Burkhard / Husband 3200 BAker Circle, Apt. I-107, Adamstown, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 2, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Resthaven Crematory Frederick, Maryland Resthaven Funeral Services, Skkot Cody P.A. 21. Signature of Fureral Service Lice 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Anterio Scienoric CAMPIOLASCULAR DISEAJE 10411 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner If thy leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Cher (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Deme youA 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 2 No 1 Tyes 1 Yes 2 ANO Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ျှ 1 ☐ Yes 2 ☐ ₩6 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 24 hours after death. 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D cal 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D-31912 1,VD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julio Mergen no 1 1564 070514m20hn MO MEDE MILL 31. Date filed (Month, Day, Year) 32. Registray's Signature State

Registrar

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AUG 0 3

2004

		•	For State Registrar	State of M	Maryland / D	Depar		Health ar	nd Mental H	_) 4	25854
	Physicia	n	1. Decedent's Name (First, Middle, Last, Claud	ia M Bu	ıllock			•	2. Date of D Month	Death Day 2	Year 4	3. Time of Death
	/Medica Examine	r	4a. Facility Name (If not institution, give Doctor's Commun				4b. City, Town,	or Location of [4c. Count	y of Death	Georges
	Funeral Director		5. Social Security Number 6. Sec		Age (In yrs. last birt		If Under 1 Year Months Days		Hrs. 8. Date of B	Sak Year 944		place (State or Foreign
Q			Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr							10d. Inside City Limits
the Mar	28e-f sl	rector	Md. Prince	Georges	G1e	n A	rden			10g. Citizen of	What Cou	1X Yes 2 □ No
F eath with	nust be	Funeral Director	1403 7th Street	12. Was Decede	at Ever in 11 C	12 144	2	20786	2/0		USA	
1 th Bullowf d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene, instural, or items 23a or 28e-f show Importent; if item 27 is marked other then "netural, or items 23a or 28e-f show any injury or other treumatic event. The Medical Examinar must be notified at once.	by Fun	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? (] No		as Decement or l Yes, specify Cub		? (Specify Yes or N Puerto Rican, etc.)	Speci	ack, White,	can Indian, etc. 1ack
215-0	e. en "netul Medical	Completed by	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4d		Deceder (Give kir life. DC	nt's Usual Occu nd of work done O NOT use retire	pation during most or ed)	f working	16b. Kind of B		•
$\sqrt{e/\mu}$ ryland 2121	d Hygien other th	e Con	17. Father's Name (First, Middle, Last)	2	C	red	entia1		inator Name (First, Middl			ndustry
$\ell = \sqrt{e/\hbar} \eta$ Maryland 2121	i and Mental H is marked of reumatic even	To Be	Claude Perry 19a. Informant's Name/Relationship (Ty	ne. Print)	19b	Mailing	Address (Street		en Yelit		State 7ir	Codol
id. e, Ma	Health ar sm 27 is ther treu	u u	Parker Bullock				7th St Arden,		or Rural Route Num.	0786		
Ulaychia Baltimore, Mar	ment of H ent: If ite ury or of		20a. Method of Disposition 1	emoval from Sta	te cemeter	y, crema	anscer	ice)	Date 3/06/04	20c. Location	•	
Balt Permit.	Departimporting any inj		21. Signature of Funeral Service Licens	Wull	10 767	, Ra	Name and Addre	ess of Facility	Funera	1 Serv	ice	20003
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each	line.	ot enter	the mode of dyi	ng, such as car	rdiac or respiratory	arrest,	DC .	Approximate Interval Between Onset and Death
/	nysician Medical xaminer		disease or condition resulting in death)		as a consequence		mbolis.	~				Unknown
per	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	as a consequence o	of):						
8760, cate be execu	hysicien and he burial-transit	IIcai Exar	that initiated events resulting in death) Last	Due to (or a	as a consequence o	of):						
X 687	attending phys	VMedic	IF FEMALE:	3c. If yes, outcom	ne of pregnancy					224 Da	A = 4 d = 15	
P.O. Box	by the atter ached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal déath at time of death		ctopic pregnanc Other (specify) _	у		1	ite of delive onth	Day Year
	been signed by the should be detached	2	Part II. Other significant conditions con	^	but not resulting in	the unde	erlying cause gn	ven in Part I.				ne cause of death?
	is certificate has be director, page 2 sh	Completed								opsy formed?	prior to cor death?	psy findings available mpletion of cause of
of Vita	this certificate al director, pag	0	TE TOS ZIZNO		tient 2 ☐ ER/Out	patient	3□ DOA Ott	ner: 4 ☐ Nursir	Death (Check only		ier (Specify	()
Vision C	fter	arlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Ir (Month, L	jury 28b. Ti Jay Year) In	ime of njury	28c. Inju	ryat rk? Yes 2 □ No	28d. Describe	how injury occur	red	
Divis	s after de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I building,	njury - At home, far etc. <i>(Specify)</i>	m, street	t, factory, office		28f. Location City or To	(Street and Numb own, State)	er or Rura	l Route Number,
ne Hospit	n 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the besiner: On the basis and manner	of examination and	death o	ccurred at the ti stigation, in my o	me, date and p opinion, death o	lace, and due to the	cause(s) and mand and place,	anner as stand due to	ated. the cause(s)
Total Total	Tott		29b. Signature and title of certifier	_ , ,	10.		29c. Licens	Se number		29d. Date signe		Day, Year)
An	8		30. Name and address of person who co	mpleted cause of	death (Item 23a) (Type, Pri	int\					D 20902
	State Registra	e r	31. Date filed (Month, Day, Year) AUG 0 3 2004	32. Regis	strar's Signature	عمد	,	C 1 04/	- 1		U	1) - (V

			1 - For State Registrer	State of Mary	land / Dep	artment of I	Health and	Mental Hy	giene			
	-		Registrer Decedent's Name (First, Middle, Last)			rimouto or	Death	2. Date of De	Reg. No.	0013	3. Tin	ne of Death
П	Physicia			Joseph C.	Brink			JUTY	3 Day	Jon 4	15	
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Dea		4c.	County of Deat	th	
ı		٠. ۵	Doctor's Community	Hospital		Lanl	ham		P:	rince G	eorge	's
	Funeral		5. Social Security Number 6. Sex		yrs. last birthday	If Under 1 Year Months Days			th			ate or Foreign
	Director		220 40 3004	X M 2□F	61 Yrs.			Nov 18	, 194			vania
	and *		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation					10d Insid	de City Limits
	Aaryli f sho	ō	Maryland Prince G		,,		a la					Yes 2 No
	the 1	Directo	10e. Street and Number	orge s		10f. Zip Code	nham		10g. Cit	izen of What Co	ountry?	
	hours after death with the Maryland tural', or Items 23a or 28e-f show al Evantret must be redified at	Ö	9412 Woodberry S	Street		207	706			USA	,	
	ms 2	Funerai	11. Marital Status	12. Was Decedent Ever	r in U.S. 13	Was Decedent of I		Specify Yes or No		14. Race - Ame	nican India	n,
٥	or Ite		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give		1 ☐ Yes 2 ☑ No		to Rican, etc.)		Black, White	e, etc.	
3	ours iral',	d by	3 Widowed 4 Divorced	Year or Dates:						Specify: Wh	nite	
9500-91212	4 within 72 hours after death with the Marylan tilen. Han Bedical Erammer must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dec	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of wo	rking	16b. Ki	nd of Business/	Industry	
7	filed within 72 Hygiene. Ither then "natent, the Medic	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	1				_			
	Hyg the		17. Father's Name (First, Middle, Last)			Traffic (me (First, Middle,		Private Sumama)		
Maryland	d be ental ked o	To Be	Joseph W. Brink				E	Rena E. W	Jalko	ar.		
2	shoul nd M	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mai	ing Address (Street					Zip Code)	
	nd 2 alth a 27 is		Barbara D. Brink	(Wife)	941	2 Woodber	ry Stree	et, Lanha	m. M	1D 20706	5	
<u>o</u>	es 1 and of Healt fitem 2 r other		20a. Method of Disposition	2		osition (Name of ematory or other pla		Date		cation - City or		е
Ĕ			1 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Ft. Lin	coln Ceme	etery 8/	5/04	$Br\epsilon$	entwood,	MD	
Baltimore,	permit. Pag Department Importent: eny injury c		21. Signature Fineral Service License	e //	. 2	2. Name and Addre	ess of Facility Re	ndon/Hal	e Fu	neral E	Iome	
n —	89 2 2 9	\$1. B	Junino	gonl		9013 Anna	ipolis Ro	ad, Lanh	am,	MD 2070)6	
п			23a. Part1 Enter the disease, or compli shock, or heart failure. List only of	octions that caused the ie cause on each line.	death. Do not er	iter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,			Between
	Pnysician	4	Im ediate Cause (Final ease or condition	Myocar	rdial in	farctio	M				,	and Death
	/Medical Examiner	(C)	resulting in death)	Due t (or as a co	onsequence of):							
	Lxammer	_	Sequentially list conditions,	Diabe Due to (or as a co		ellitus					15	Y5.
	pe jist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	COYON		Artery.	dingan	,			101	4.4.0
	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a co		11 00.0	00032007				10	113.
29/	tte be executed iysician and ne burial-transit	caiE		Hure	xtens	sion					10	yrs.
89	ificate g phy as the			· · · · · · · · · · · · · · · · · · ·		-			-			
X Q Q	anding use	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		75			2	23d. Date of deli	very	
	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time		□Ectopic pregnanc □ Other (specify) _	у			Month	Day	Year
J O	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	9 Dunknown									
	res tha	by	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.			se contribute to		
or o	w require	ted						101	Yes 2[JNo 3 ☑ Pro	obabiy 4	Unknown
Hecords,	e law has b	Completed						24a. Was autop	SV	24b. Were au	topsy findir completion	ngs available of cause of
<u> </u>	10 77	Cor							rmed? 2 2 No	death?	2□ No	
VII	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	/	Ott	oor	ath (Check only o				
o	Phys r this ral dii	. To	1 ✓ Yes 2 ☐ No	1 Inpatient 28a. Date of Injury	2 FR/Outpatie	nt 3 L DOA	4 Nursing F	Home 5 Resid			city)	
o	ding F th. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	par) Injury	Wo	rk? Yes 2 □ No	200. 003011001	iow injury	CCCUTTGG		
Division	or Attending after death. Director: After in by the funer	fica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, s			28f. Location (S	Street and	d Number or Ru	ral Route N	Vumber,
É	i Sir fe	Certification;	4 Homicide	building, etc. (S	Specify)			City or Tou	vn, State)	1		
	Hospitel		29a. Certifier 1 Certifying Phys	sician: To the best of m	y knowledge, dea	th occurred at the ti	me, date and place	e, and due to the	cause(s)	and manner as	stated.	
	the Hos in 24 hc the Fun pletely	Medical	one)	ner: On the basis of exa and manner stated.	amination and/or i			arred at the time, o	Jate and	place, and due	to the caus	₃e(s)
	To the within 2.	Σ	29b. Signature and title of certifier	Lanalenn	NA D	29c. Licens			29d. Date	e signed (Month	1	r)
	(/8)		tulians	consul III	MI	DOC	12001			210	ナ	
0	20		30. Name and address of person who co	mpleted cause of death	(Item 23a) Type	Print) rrollto	n MD	20-	78	4.	0.04.0	
	Sta	te.	31 Date filed (Month, Day Year)	32. Registrar's	Signature				FP	R HAD J	MINHL	1 MD
	Registr		AUG 0 3 2004	en It	Sperke							

Ame	nde	ed,#4a	,	State of Maryland / Department of Health and State 106, M.D., TCHD, 7/27/04, sblocertificate of Death	d Mental Hygi	ene g. N2 0	04	25856
		Dhusiei		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month		Year	3. Time of Death
		Physici /Medi		LILLIE MAE BAYNARD	JULY	^{Day} 25	2004	6:28PM M
		Examir	ner	4a. Eacility Name (If not institution, give street and number) 29943 Beaver Dam Road TRAPPE	eath	4c. Cour	ity of Death TALB(OT
		Funeral Director		214-74-6548 99 Yrs.	Irs. 8. Date of Birth (Month, Day, MAR 13	Year) 1905	Coun	lace (State or Foreign try) 'LAND
		land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			11	0d. Inside City Limits
		ith the Marylar or 28a-f show e notified at	ţċ	MD TALBOT TRAPPE				1 ☐ Yes 2X No
		death with the Maryland sms 23a or 28a-f show r must be notified at	Director	10e. Street and Number 29943 Beaver Dam Road 10f. Zip Code	10	g. Citizen o	f What Coun	itry?
		sath w		216/3 216/3	(S-sett - V-s - N-s	14 B	USA	
		after dea or Items	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	erto Rican, etc.)		ack, White,	
	21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. tem 27 Is marked other than "natural", or Items 23a or 28a-f shon other traumatic evant, Tre Medical Exammet must be notified a	þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 No Specify:		Spec	ify: WHI	TE
	15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of will be DO NOT use retired)	working 1	6b. Kind of	Business/Inc	lustry
	712	withir iene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+) 7 O HOMEMAKER		OWN	HOME	
	þ	il Hyg other	O		lame (First, Middle, M			
	/lar	wild be Menta arked atic ev	To B	WILLIAM CHRISTOPHER SU	DA HOPKINS			
	Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or				Code)
	e, l	Health tem 27		DORIS B. RILEY/DAUGHTER 29943 BEAVER DAM R 20a. Method of Disposition (Name of			1673 1 - City or To	wn State
	Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	- 1			
	Ħ	nit. Partme ortan injury		*4 □Donation 5 □Other (Specify) SPRING HILL CEMETERY 7 - 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	29-2004	EASTO.	N, MAR	YLAND
	B	Departi Departi Importany in		TOHN & MERCERO FELLOWS, HELFENBE	IN & NEWNA	M FUN	ERAL H	IOME PA
				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	TEASTON, liac or respiratory arres	MD Z1	601	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition Dementic				Onset and Death
	1	/Medical Examiner		resulting in death) Due to (or as a consequence of):				>
		LAMITHE	-E	Sequentially list conditions, if any, leading to immediate Doe to (or as a consequence of).				
	П	uted I Insit	Examiner	Cause (Disease or injury				
	ó	ate be execute hysician and the burial-trans		that initiated events ' c Due to (or as a consequence of):				
	Box 68760,	ate be nysiciá he bu	Icai	d				
	39)	eath certifica attending ph i for use as th	Med	IF FEMALE:				
	B0)	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?			ate of deliver	ry Day Year
	P.O.	at the de by the a tached t	Physician/Med	1 Yes 2000 4 Pregnant at time of death 5 Other (specify)9 Unknown				ŕ
		res that tigned by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use cor	ntribute to the	e cause of death?
	Vital Records,	quires in sign	ed by		1 ☐ Yes	2 100	3 🗌 Proba	ably 4 Unknown
	00	aw requir is been si 2 should	Completed		24a. Was an	24b.	. Were autop	osy findings available of
	<u>~</u>	The lav ate has page 2 a	mo;		autopsy perform 1 ☐ Yes 2	ed?	death?	No
	ita	ysician: The is certificate hadirector, page	Be (examper?	eath (Check only one)			
8	of \	Physic this or	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing)
1		dling F h. After funera	<u></u>	27. Manner of leath 1 Natural 5 Pending (Month, Day Year) 1 Nocident investigation 28a. Date of Injury (28b. Time of Injury Work? M 1 Yes 2 No	28d. Describe how	v injury occu	irred	
,	Division	Attandil death. ctor: A y the fu	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Num	ber or Rural	Route Number.
	Ξ	al or A after I Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one)	ce, and due to the cau curred at the time, dat	ise(s) and m e and place	nanner as sta , and due to	ited. the cause(s)
		o the	Med	29b. Signatore and title of certifier 29c. License number	290	d. Date sign	ed (Month, D	ay, Year)
		⊢ s ⊢ ō		May 1/2. 751762		7/2	7/11	
				30. Name and riddress of person who completed cause of death (Item 23a) (Type, Print)		10	1107,	
				Zugene Newmier DO 503 Bus	on 5+ (am	midy 6	MD,
		Sta Registr		31. Date filed (forth, Day, Year) 32. Registrar's Signature			1	01613

			1 - For State Registrar	State o	f Maryla	-	artmen rtificat			d Mental	Reg. N	2111) 4	258	357
	Physici /Medio		Decedent's Name (First, Middle, La GEORGE BURNHAM	IV						2. Date Month	y 26		Yeer 0 0 4	5:45	of Death
	Examir	ner	4a. Fecility Name (If not institution, given Genesis Elder) 5. Social Security Number 6. S	Care -	The P	ines	4b. City,	Εa	Location of Do aston			Τέ	of Deeth	t	ar Forniar
	Funeral Director			X M 2□F	86	Yrs.	Months			fin. (Mont NOV	of Birth h, Day, Yeer 18 19	17	PA.	plece (State intry)	s or Foreign
	a-f show	ctor	10a. State 10b. County MD TAI	вот	10c. C	EASTON								10d. Inside 1 ☐ Ye	City Limits es X⊠No
15-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than *natural', or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exapter must be notified at once.	Completed by Funeral Director	10e. Street and Number 6515 DIAMOND HA 11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr.	12. Was Dece Armed Fo 1 X Yes If Yes, Gin Year or D ducation ade completed)	2 □ No /e ates:	16a. Dece	1 ☐ Yes	21 dent of History Cuba 22 No	Specify:	(Specify Yes Jerto Rican, etc	or No-	14. Rac Blac Specify	ck, White	can Indian, etc.	
n d 2121	filed within Hygiene. other than		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last	College (1	I-4or 5+)		CE PI		ENT	Name (First, M			_	RATIO	N
Burnham, Maryland	should be ind Mental I	To Be	GEORGE BURNHAM I	II		10h Maili	a a Addrosa	(Street)	MAR	GARET M	ANI GAI	<u>L</u>		- Codel	
Bur e, Mai	t and 2 sl Health and m 27 is r ther traur		SHIRLEY C. BURNHA		20h		ВОХ	40		OAK MD	21662				
George E Baltimore,	it. Pages rtment of tr rtant: if ite njury or of		20a. Method of Disposition 1 Burial 2 Cremation 3 C 4 Donation 5 Other (Special	(y)	State	cemetery, crei ESAPEAK	matory or o	ther plac MATI	ON CTR	7-27-2				own, State	MD
Ged Bal	permit. Depart Import any inj		21. Signature of Funeral Service Lice	. MER	CER		ELLOV 00 S	IS, I HAF		EIN & N ST EAST		FUNI 216	ERAL 501		
68760,	Physician / Medical Examiner site priging is the priging transit	edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Super itsily list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pro Due to	ach line. Static (or as a consecto	quence of):		,		to bon				Approxim Interval Br Onset and	etween d Death
P.O. Box	The law requires that the death certitica ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		irth 2 Fet	al death 3	⊒Ectopic pr □ Other (sp						te of deliv	ery Day	Year
	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions of	contributing to de	eath but not re	sulting in the u	nderlying c	ause give	on in Part I.		Did tobacco 1 ☐ Yes 2	_	ribute to t		death? Unknown
Division of Vital Records,	The law requate has been page 2 should	Completed								- 1	Was an autopsy performed?	1	Were auto prior to co death?	ppsy findings mpletion of 2 No	s available cause of
Vita	ysician: s certific director,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2] ER/Outpatier	nt 3 DC	A Othe		Death (Check of		6 □Oth	er (Specii	5v)	-
ion of	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely tilled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date (Mont	of Injury th, Day Yeer)	28b. Time o		8c. Injury Work			ribe how inju			y /	
Divis	al or Atte s after de: al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	289. Place	of Injury - At I ng, etc. (Spec	nome, farm, str	reet, factory	, office			on (Street a r Town, Stat		er or Rura	al Route Nu	mber,
	the Hospital hin 24 hours a the Funeral I apletely tilled	Medical (29a. Certifier (Check only one) Certifying Pl	niner: On the ba	best of my kn asis of examin ner stated.	owledge, death ation and/or in	h occurred vestigation	at the tim	e, date and pla pinion, death or	ace, and due to occurred at the t	the cause(s	and ma d place, a	inner as s and due to	tated. the cause	(s)
	To the To the comp	Ň	29b. Signature and title of certifier	flow.	enses		290	. License	number 77259	33	29d. Da	7.20	6.04	Dey, Year)	
	Sta Registr		30. Name and address of person who MICIAL CRCLA 31. Date filed (Month, Day, Year)	JULY P	e of death (Ite	508	Print) LDL	(1)	W A	MINUE	E	7570	in P	102	1601

DHMH 17 Rev 1/2001

ORIGINAL

		1 - State Registrar	State of Mary	-	artment of rtificate of		•	giene Rog. No2 (004	258	159		
Physici	an	Decedent's Name (First, Middle, Last	,	_			2. Date of De		Year	3. Time of			
-/Medic			Irma E. Ba	aker			July	26 ^{Day} 2	20ď4 ^r	5:15	P۳		
Examin	ner	4a. Facility Name (If not institution, give			4c. County of Death								
		2150 Troon Overloo 5. Social Security Number 6. Se		a ura laat histhdau	Woods If Under 1 Year		0.0(17)	Howard					
Funeral Director			x 20XF 7. Age (//	n yrs. last birthday Yrs.	Months Days		8. Date of Bir (Month, Da Aug 20	, 1921	9. Birthplace (State or Foreign Country) 1921 Maryland				
MO T		10a. State 10b. County	10	c. City, Town or L	ocation					l Od. Inside Ci	ity Limit		
rs j-e	tor	MD Howard		Woodsto	ck					1 🗌 Yes	2 🖪 N		
or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?			
23e	ral	2150-103 Troon Ove	erlook		2116	53	Unit	ed Sta	ates				
ltems list m	une	11. Marital Status	Armed Forces?	2. Was Decedent Ever in U.S. 13. Marked Forces?		Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. R	14. Race - American Indian, Black, White, etc. Specify: White				
f Health and Mental Hygiene. item 27 Is marked other then "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Spec					
lical I	Completed	15. Decedent's Edu		16a. Dece	dent's Usual Occu	pation		16b. Kind of	. Kind of Business/Industry				
	nple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retire	during most of work od)	ang						
Hygiene. other then ent, the N	Con		2	He	omemaker	-		Own Home					
ital H id off even	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Maiden Sumame)						
and Mental I Is marked o eumatic eve	2	John Adam Huf		Laura B.									
h and 7 Is n		19a. Informant's Name/Relationship (T)	•			and Number or Rura							
Health tem 27 other tr		Elaine Roussos/Dau 20a. Method of Disposition		2150. 20b. Place of Dispo		on Overloo	K WOODS	tock,					
		1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	cometery, cre Good She	matory or other pla	ice)	-2004			ty, M	`		
Department of Importent: If any injury or once		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens		-	-	1				-			
lmp any onc		Ky Collins	MO1	044	112 013 (ess of Facility Har	ry H. W	itzke':	s Fami	Ly FH	Inc		
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	death. Do not en	ter the mode of dyi	Columbia Ping, such as cardiac o	TKE ETT or respiratory ar	rest,	LILY,	Approximate	9		
nysician		Immediate Cause (Final								Interval Bety Onset and D	veen)eath		
Medical		Immediate Cause (Final disease or condition resulting in death) a. Acute Myocamial Infarction Due to (or as a consequence of): b. Conor Ary Artery Disease If any leading to immediate Due to (or as a consequence of):									K		
xaminer		CORONAN ANTON DISPESO									BA		
=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequen of):	7								
and trans	Examiner	C. Cause (Disease or injury that initiated events c. Pue to for as a consequence of):											
hysician and he burial-transit	Ē	Todaking in additity East	Due to (or as a co	insequence of):					1				
physi s the b	dical		J										
e attending physician and ad for use as the burial-transit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy							23d. Date of delivery				
atter I tor u	ciar	in the past 12 months?	decedent pregnant						Month Day Year				
by the	iysi	9 Unknown											
de de	by Pl	Part II. Other significant conditions cor	23e. Did to	23e. Did tobacco use contribute to the cause of death?									
n sign uld be		Chronic ObsTE	UCTIVE PL	1 monory	Diseo	50	es 2 🗆 No	2 No 3 Probably 4 Unknown					
s been s	Completed	24a. Was an								24b. Were autopsy findings available prior to completion of cause of			
모 9	mo						autop: perfor	med?	death?		use ol		
certificate ector, pag	0	25. Was case referred to medical				26. Place of Death	1 Tes		1 🗌 Yes	2□No			
w ==	To B	examiner? 1 ☐ Yes 2 XNo		9 5 ☑ Residence 6 ☐ Other (Specify)									
th. : Atter thi : funeral		27. Manner of Death 1 XNatural 5 ☐ Pending	y at it	28d. Describe how injury occurred									
r death. ector: Atter by the fune	atle	2 Accident investigation											
atter d Direct I in by 1	Certification:								ion (Street and Number or Rural Route Number, or Town, State)				
urs al													
within 24 hours after deat To the Funerel Director; completely filled in by the	dical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	sician: To the best of ma ner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	noccurred at the tile vestigation, in my control of the control of	me, date and place, a pinion, death occurre	and due to the c ed at the time, d	ause(s) and m ate and place	nanner as sta , and due to	ated. the cause(s)			
within 2 To the complet									Date signed (Month, Day, Year)				
8 ⊢ 8		Froclose	KU	m									
2		30. Name and address of person who co	mn eted cause of door	(Item 22a) /Tim-	Drint)	33636	1	July 2	21, 20	04			
		our and address of person who co	Pieren canse oi negiu	(110111 232) (1ype,	7 IIII	1 4-	//	/	4.4				
		FIEDERICK KIM	w ma 3	449 (20)	CPAS A	ve or 30	2 /5m	TAMO	p /1	0 21	77		

	State of Maryland / Depart Certii	ment of Health and N ficate of Death	/lental Hygiene Rog. No.∏ (14 25850								
Physician /Medical	STEPHANIE RETORD		2. Dete of Deeth _ Month Day	3. Time of Death 2004 3:00pm								
Examiner	A. E. W. A. W. M. M. M. M. M. M. M. M. M. M. M. M. M.	4b. City, Town, or L Columbia	172-11111	nty of Deeth								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey)	f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Dey, Year) Jan 14, 1910	Birthplace (State or Foreign Country) Massachusetts								
the Maryland 128e-f show northed at	10a. Stete 10b. County 10c. City, Town or Locati	ion	4.	10d. Inside City Limits 1 ☐ Yes 2 ဩNo								
with the Ma 3a or 28a-f s If be northed		10f. Zip Code 21045		f Whet Country?								
within 72 hours efter death with the Manyland within 72 hours efter death with the Manyland end. Madical Examiner must be notified at property or property or property or property or property.	11. Merital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	Decedent of Hispanic Origin? (Sp is, specify Cuban, Mexican, Puerto Yes 2√2 No Specify:		ed States ace - American Indian, ack, White, etc. ify: White								
_ = E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) HOUSE	's Usuel Occupetion d of work done during most of work NOT use retired)	ing 16b. Kind of I	d of Business/Industry								
ges 1 and 2 should be filed to the eith and Mental Hygin if Item 27 is marked other or other traumatic avant,	17. Fether's Neme (First, Middle, Last)	18. Mother's Name	O. Bayarunaio	me)								
	19a. Informent's Name/Reletionship (Type, Print) Evelyn McGettigan/Daughter 5445 A	ddress (Street and Number or Run	al Route Number, City or Town	n, State, Zip Code)								
emit. Peges 1 er Depertment of Hee Mportant: If Item 2 Iny Injury or other MCe.	20a. Method of Disposition 1 Burial 2 Cremation 3X Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition cemetery, cremato	ry or other plece)	Date 20c. Location 2-2004 Athol,	- City or Town, State								
pemit. Depert import any inj once.	Har	me and Address of Fecility TY H. Witzke's I	Family Funeral	Home, Inc.								
Physician /Medical	23a. Peri 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death										
Examiner	disease or condition resulting in death) Dementia Due to (or as e consequen	ce of):		years								
ficete be executed physician end st the bunel-trensit edical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	uence of):										
ne death the atter thed for a	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death?								
es thet the death certigned by the attendine be deteched for use by Physician/N			1 ☐ Yas 21 ☑ No	3 ☐ Probably 4 ☐ Unknown								
sw requir			24a. Was en eutopsy performed? 24b. Were eutopsy findi available prior to completion of caus of death?									
ysician: The is s certificate he director, page To Be Com	25. Was case referred to medical examiner?	26. Place of Death	1 ☐ Yes 2 ☑ No (Check only one)	1 ☐ Yes 2 ☐ No								
Attanding Physicien: or deeth. actor: After this certificaty the funerel director, by the funerel director, iffication: To Be (Hospital:	DOA Other: 4X Nursing Hon 28c. Injury et Work?		Residence 6 Other (Specify) ribe how injury occurred								
To the Hospital or Attanding Pl within 24 hours effer deeth. To the Funeral Diractor: After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	actory, office 2	28f. Location (Street and Number or Rural Route Number City or Town, State)									
Hospit 124 hour Funeral letely fill	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.											
Withir To the comp	29b. Signature end title di certifier	29c. License number	29d. Date signe	29d. Date signed (Month, Day, Year)								
)02	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print		July	29, 2004								
State	William Saway MD 2 Knoll North Columbia 31. Dete filed (Month, Day, Year) 32. Restrer's Signeture											
Registrar	AUG 0 3 2004 Mesen & Some	de 1										

ORIGINAL

DHMH 16 Rev 6/95

_			For State Registrar			f Maryla		artmen rtificat				lental Hy	giene Reg. No.	004	25860
	Physic	ian	Decedent's Name		,		17		,			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi	cal		Wai		A	BAX		yr			AUG	4	2007	3:30 PM
1	Exami	ner	4a. Facility Name (If							Location	of Death		4c.	County of Dea	
			Howard Co						olum					Howard	
	Funeral Director		5. Social Security Nu 158 18 98		6. Sex 1 M 2 □ F	7. Age (In yrs	s. last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th y, Year)		thplace (State or Foreign ountry)
		4	Usual Residence of			/6						Oct 16	, 19	27 ∣ N∈	w Jersey
	yland		10a. State	10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
:1215-0036 within 72 hours after death with the Maryland	Mar Mar	ğ	MD	Howard	Ē	E	llicott	City							1 ☐ Yes 2 🔯 No
	h the	rec	10e. Street and Num	ber			1110000	10f. Zip					10g. Citiz	en of What Co	ountry?
	th wit	Funeral Director	3110 Gree	nway Di	cive			2	1042				_	ited St	•
	d within 72 hours after death with the Marylan jone r than "natural", or items 23a or 28a-f show the Medical Exactions must be notified at	ner	11. Marital Status		12. Was Dece	dent Ever in	U.S. 13.	Nas Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No		4. Race - Ame	erican Indian,
9	or its	E	1 Never Marrie	d 1 ☐ Yes	1 ☐ Yes 2X No If Yes, Give 1 Year or Dates:			Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 No Specify:			Hican, etc.)		Black, White, etc.		
8	uraf,	To Be Completed by	3 Widowed 4	Year or Da									Specify: White		
5	natu		(Specif	15. Decedent's y only highest	s Education grade completed)		16a. Deced	kind of wor	k done d	urina mos	t of work	ina	16b. Kin	d of Business	Industry
121	within ne. than		Elementary/Secon	dary (0-12)	College (1	-4or 5+)	life. I	OO NOT us	e retired)						
7	77 75 10 10		17. Father's Name (F	int Middle I	4		ETE	ctric							tal Element:
and	be de la la la la la la la la la la la la la									18. Mothe	r's Name	(First, Middle,	Maiden S	Surname)	
ž	should but marked		Walter A.]	Mary	A. <i>V</i>	Valter			
Maryland 21215-0036	2 6 3 6		Janet B. I									al Route Numbe			
dî.	1 and Health em 27 ther tr		20a. Method of Dispo		мтте	20h	SITU	Gree	nway	Driv	re El	licott			
Baltimore,	nges or o		1 X Burial 2	Cremation :	3 □Removal from S		Place of Dispo cemetery, cren					Date		ation - City or	
Ξ	t. Pa		`4 □Donation 5				est La						Marr	iottsv.	ille, MD
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Fun	~ Coll	no-ut	044 Ri	4.	LTZ O.	ta C	OLUMB	ıa F	ike Ell	icot	's Fam t City	ily FH Inc.
Pr			23a. Part1. Enter the shock, or heart	disease, or c failure. List o	my one cause on ea	ica inne.	th. Do not ente	er the mode	of dying	, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (F disease or condition	inal		CONG	ESTIVE	EL	IEAC	T	E	luca			Onset and Death
	/Medical Examiner		resulting in death)	1	Due to (c	or as a conse	quence of):				1-	770700			
	Cxammer		Securitally list none	Micra	Ь.	Isch	Enic	6	ANC	piano	1/5	FNY			
	p #	by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a.												
cute	cate be executed physician and the burial-transit		that initiated events c. Due to (or as a consequence of):												
8760,	sian surial														
87	ate b				d										
9 2	entific ling p	Me	IF FEMALE:								- 177		-1		
Вох	es that the death certifi igned by the attending be detached for use as	an	23b. Was decedent a in the past 12 m	oregnant		th 2 ☐ Feta	al death 3 🗌	Ectopic pre	gnancy				23	d. Date of deli	•
<u>.</u>	e de the a	Sic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4☐ Pregna 9☐ Unkno	nt at time of o	death 5	Other (spe	cify)					Month	Day Year
P.O.	d by	Ph													
S,	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										co use contribute to the cause of death?		
0.0	w require been sign	Completed								1 🗆 Y	bably 4 DUnknown				
ec	elaw hasb ye 2 st											24a. Was a		24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	The	Con										perfor		death?	2D No
/ita	cian; artific ictor,	Be (25. Was case referre examiner?	d to medical						26. Place	of Death	(Check only or			7-110
=	hysis his c	P.	1 Yes 2 N	0			ER/Outpatient	3 DOA	Other	4 □ Nur	sing Hon	ne 5 🗆 Reside	ence 6 (☐Other (Spec	ify)
Division of Vital Record	ng P After t	on:	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe (Month, Day Year) Injury Work?								8d. Describe ho	e how injury occurred			
	eath.	cati	2 Accident investigation M 1 Yes 2 No							lo					
Ξ	ter d irect irect	Certification:	3 ☐ Suicide 4 ☐ Homicide	determin	ad 28e. Place o	 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 					28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	ital c														
	To the Hospital or Attending Physician: The la within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 (Check only 2	✓ Certifying ☐ Medical Ex	Physician: To the base	est of my kno	wiedge, death	occurred at	the time	, date and	place, a	nd due to the c	ause(s) ai	nd manner as	stated.
	the h	led			and manne	er stated.					occure	d at the time, d	ate and p	lace, and due t	to the cause(s)
	So Twitt	Σ	29b. Signature and tit	le of certifier	6			29c.	License i	number		_ 2	9d. Date :	signed (Month,	Day, Year)
1	1),		· Ke	en.			1.0		100	56	64	5	AU	6 4,	2004
(200		30. Name and address	s of person wh	o completed cause	of death (Item	n 23a) (Type, P	rint) KA	114	F	ZIF	mad			
	0		30. Name and addres	L.H.	1= Pato	ンモル	Pan	Kwn	5	5017	~ 10	01 C	100	612 M	0 21074
	Sta	.6							,						
	Registr	ar	ΔI	IG 06	2004	Peace.	K 1								

			1 - For State Registrar	State of Maryla	•	artment of H			giene Reg. No 20	04	25861
ı	Physici /Medic		Decedent's Name (First, Middle, Last) Evelyn	С		Bea	rd	2. Date of De. Month August	2 ^{Day} 200	4. Year	3. Time of Death 11:00PM M
	Examin		4a. Fecility Name (If not institution, give Waldorf Health Ca			4b. City, Town, or Waldor	Location of Deat	h	4c. County Char		
Ì	Funeral Director		218 66 6408	7. Age (In yi	rs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da Oct 20	h y, Year) , 1909	9. Birthp Court Pa	place (State or Foreign ntry)
	Maryland -f show fled at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		City, Town or Lo					1	1 ☐ Yes XX
	h with the 23e or 28e	Direc	10e. Street and Number 6210 44th Ave			10f. Zip Code 20	737		10g. Citizen of V		-
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic evant, the Medical Examirer challed in pulling at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒️X dowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of H I Yes, specify Cuba I ☐ Yes 2\\X\\	ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Blac	e - Americ ck, White, v: Whi	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vant, II e Manical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired USEWife	ation during most of wo f)	rking	16b. Kind of B	usiness/Ind	
land 2	uld be filed Mental Hygi irked other itic evant, I	To Be Co	17. Father's Name (First, Middle, Last) John G. Justice					me (First, Middle, rence R.		7e)	
2	1 and Health em 27 ther tr	•	19a. Informant's Name/Relationship (Ty E. Christine Black) 20a. Method of Disposition	well(Daughte	er) 1470	sition (Name of	Calvert 1		-	lboro	,MD 20772
Baltimore,	Pa ant ury		1 XX urial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	1	Rose Hil	natory or other place 1 Cemetes Name and Address	ry Aug 6	, 2004 ee Funer			Maryland
Ba	permit. Departr Importe any inj		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	M065H2	Alexandr	ia Ferry	RD Cli		MD20735 Approximate Interval Between		
8760,	Physician /Medical Examiner bhysician and the pright transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons	equence of):	1087C	CAAI)	10UAR	COLAGI	- 00	Onset and Death
.O. Box 68	The law requires that the death certific: ste has been signed by the attending pl page 2 should be detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 3 No 9 ☐ Unknown	3c. If yes, outcome of prec 1 □ Live birth 2 □ Fr 4 □ Pregnant at time o 9 □ Unknown	etal death 3	Ectopic pregnancy			23d. Dai Mo	te of delive	ery Day Year
<u>α</u>	quires that t n signed by uld be deta	by	Part II. Dther significant conditions col	ntributing to death but not a	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	2	ribute to th	ne cause of death? ably 4 □Unknown
al Records,		Completed							rmed?	Were autoportion to condeath?	psy findings available mpletion of cause of 2 No
Division of Vital	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	Certification; To Be	25. Was case referred to medical examiner? 1	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str	28c. Injun Word M 1	er: 4 XNursing ⊦ ⁄at		dence 6 Oth	red	r) I Route Number,
	To the Hospitel of within 24 hours at To the Funeral Completely filled in	edical Ce	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinate	sician: To the best of my k ner: On the basis of exam and manner stated.	nowledge, death	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	and due to the ourred at the time, o	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier		1	29c. License	number 1854	5 4	29d. Date signed	d (Month, l	Day, Year) 3, 200
M	1P6		30. Name and address of person who co	MD 12070 0	ld Line	Centre #2	207 Wald	orf, Mar	yland 20	0602	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 4	2004 32. Redistrar's Sig	nature	perk					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** DOUGLAS FAIRFAX BUILER, JR. AUGUST 2, 2004 10:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GENESIS ELDER CARE LAPLATA CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1**₩** M 2□F Min. Hours 579-20-2448 84 Director MARCH 29, 1920 MARYLAND Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r than "natural", or itama 23a or 28e-f show the Medical Examiner must be notified at 10d. inside City Limits 1 Yes 2 □ No Director MD PRINCE GEORGES ACCOKEEK 10e. Street and Number 10f. Zip Code 10g. Citizen of Whaf Country? 18419 BARNEY DRIVE 20607 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Aggred Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whife, etc. Acmed Forces?

1 X Yes 2 No 1943

Yes, Give
Year or Dates: 1945 within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Set UNKNOWN /Secondary (0-12) College (1-4or 5+) BLOCKER AND BRACER FOREMAN FEDERAL COVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 is marked out DOUGLAS FAIRFAX BUILER, SR. ANGELLA CAMPBELL BUILER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARION BUILER - SISIER-IN-LAW 18419 BARNEY DRIVE, ACCOKEEK, MARYLAND 20607 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Sfate permit. Page Department o Important: If any injury or once. 1 Burial 2 Cremation 3 Removal from State MD VEIERANS CEMETERY 08/09/2004 * 4 □Donation 5 □ Other (Specify) CHELIENHAM, MARYLAND 21. Simature of Funeral Service Licensee VIONATINI PARTITUME, P.A. LIVINSSION ROAD, INDIAN HEAD, MARYLAND 20640 LADIA C. THORNION JOHNSON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 45 biration **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by t Part ff. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 1 ☐ Yes 2 No peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2 No 1 TYes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 SkNursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury af Work? 28d. Describe how injury occurred Aftert 1 Natural Injury 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D52289 814104

Registrar

State

DHMH 17 Rev 1/2001

St. Patrick's

32. Registrar's Signature

Dr., Wald., Md. 20603

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 4 2004

10

Nation Mathur

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Vear **Physician** JULY 28 2004 9:05 AM M ALBINA MAGDALEN BROOKS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT WILLIAM HILL MANOR 8. Date of Birth (Month, Day, DEC 17 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🕅 F MARYLAND 82 Director 214-16-3807 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Medical Exact at most be notified at X Yes 2 No Director EASTON TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 501 DUTCHMANS LANE IISA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRIC COMPANY 0 REWINDER 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental ! MAGDELAN PECIUELUSE JOHN WISNAUSKAS ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itam 27 i 21378 SINCLAIR AVE. TILGHMAN, MD 21671 RONALD D. BROOKS/SON other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Department of Important: If any Injury or once. CHESAPEAKE CREMATION CTR 7-29-2004 * 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS. HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee MERCERON JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one caus peach line. Approximate Interval Between Onset and Death erebrovasular Accident Immediate Cause (Final **Physician** 20 disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physicien for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2**X**/No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 2 **2** No 1 ☐ Yes 2 ☐ No certificete 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2**X**No Hospital: 1 | Inpatient Other: 4 Qursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA 2 his funeral 27. Mamer of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation death. 1 Tes 2 No 2 Accident 24 hours after death e Funeral Diractor: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide **Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29d. Date/signed (Month, Day, Year) 29c. License number 29b. Signature and title 035284 S. Washington St Eastman 2001 d cause of death (Item 23a) (Type, Print) - AUBI MO 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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item 27 is marke other treumetic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (S	Street and N	umber or Run	al Route Number	, City or Town,	State, Zip	Code)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Shirley Louise Baker 28, July 2004 12:58 p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 27, 1937 5. Social Security Number **Funeral** Min. Months Days Hours 212-34-1681 1 M 20 F 67 Director MD Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State in than "natural", or iteme 23a or 28e-f ehow the Medical Examiner must be notified at MD Anne Arundel Pasadena 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 1591 Colony Road 21122 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or item Iry or other treumatic avent, the Medical Examination. ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CSX Railroad 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Phillip Schultz, Sr. Anna Beatrice Aliff ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Tina Rothgeb/Daughter 508 South Macon St., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 2, permit. Page Department of Important: if any injury or once. Glen Burnie, MD Glen Haven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD com 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subarachund Hemorrhale Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No fo Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9☐Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 2 No 1 Yes : After this certifical funeral director, f Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: injury at Work? Hospitei or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours after Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 ho To the Functional 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 46052 7128/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Solvid Bluk, MD 2001 Medical Ponkway anapthis, MD Stoerd Beck, MO 32. Regis Ar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			1 - For State Registrar	State of Marylan	-	artment o			nd Menta		ene	25867
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	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, To	wn, or Lo	ocation of		/	4c. County of De	
			Anne Arundel Med	Rical Center	r	Annag					Anne Ar	undel
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 \ Months D		Hours		te of Birth onth, Day,	Year)	Birthplace (State or Foreign Country) [aryland
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	show	5	10a. State 10b. County		y, Town or Lo							10d. Inside City Limits 1 ☐Yes 2 ☐ No
	the M	Director	Maryland Anne Al	cundel Ani	napol:	10f. Zip Co	ode	-		10	g. Citizen of What	Country?
	h with	a D	137 Merryman Co	ourt		2	2140	03			Ü	ISA
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show army injury or other traumatic event, I're Medical Evantment must be notified at once.	Funeral		12. Was Decedent Ever in U. Armed Forces? 1∑Yes 2 ☐ No		Was Deceden f Yes, specify		anic Orig Mexican, Specify:	in? (Specify Ye Puerto Rican,	etc.)	Black, W	
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Baltimore,	permit. Departr Imports any inj		21. Signature of Funeral Service License	//	1 2	Name and A			Sons M Annap	lortu	ary, P.	A. 21401
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	Pnysician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	Nhy	000	D.	W.	Mar	chi	~	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):			-	1	-		7 11 1
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, of	ffice			cation (Stre y or Town,		Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in it	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at t vestigation, in	the time, my opin	date and tion, death	I place, and due n occurred at th	e to the cau ne time, dat	use(s) and manner e and place, and d	as stated. ue to the cause(s)
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			30. Name and address of person who co	empleted cause of death (Item	23m (Type,	Print)	(O.	12	10	Ana-	NA ONLI COL
	C)		31. Date filed (Month, Day, Year)	32. Rasstrar's Signa	ture	wed	رف	TER	my of	101	U, Miche	- Managed 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** July 1.4Pay Charles Belt 2004 1823 м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 1 22, 7. Age (In vrs. last birthday) 5 Social Security Number 213-64-0733 Birthplace (State or Foreign Country) **Funeral X**XM 2□ F Year 954 49 Director D.C. Usual Residence of Decedent death with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at aMaryland Anne Arundel Millersville 1 XYes 2 No Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1720 Belts Dr. 21108 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ½ Yes 2 □ No If Yes, Give Year or Dates:1 9 7 2 − 7 8 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify: à Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Chesapeake Construction College (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment Operator 1.0th 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph N. Jones Daisy Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health and ant: If item 27 is r 1720 Belts Dr. Millersville, Md. 21108 Daisy Belt(Mother) other t 20b. Place of Disposition (Name of Macong tanan 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State in ury or permit Page Deparment o Important: If any in ury or 7-20-04 Crownsville, Md. Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. J. Rease MOO483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart failure veaurs /Medical **Examiner** Caroliomyopathy Ischemic yeurs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit the death certificate be executed Coronary 200 (Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 npatient P 2 ER/Outpatient 3 DOA filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) yrein Beck, Mb 115/04 D46052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mor

gistrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 10:508. MA **Physician** Aniela Babula 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RUNDEL HRUNDEL HOSTITAL 8. Date of Birth (Month, Day, Year) June 1,1918 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F Yrs. Director 122-12-3236 86 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or then "natural", or items 23e or 28e-f shov the Medical Examination ust be notified at MD Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u>with</u> 5912 Winthrop Avenue 21206 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Home is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental William Jasenski Anna Kosczenska or other treumatic 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: if Item 27 is any injury or other treu 2005. Frank M. Babula/Husband 5912 Winthrop Avenue, Baltimore, MD Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State July 22, 2004 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Sected License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 224. Part 1. Epret the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 physician Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4□Pregnant at time of death 5 Cher (specify) Division of Vital Records, P.O. 9□ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has page 2 Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient 2 2 ER/Outpatient 3 DOA (his funeral Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FIND 30. Name and does of person who completed cause of death (Item 23a) (Type-Print) 1116/842 31. Date filed (Mor 2004 Registrar

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	Physic		1. Decedent's Name (First, Middle, Las John Olin Bu	t) Ichanan					2. Date of Month	Death	ay Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Se 008-03-2166	9x ▼M 2□F 7. Age (In yr. 92	s. last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min. (Month	Birth Day, Year 1 24,	9. Birth	oplace (State or Foreign intry) erby, VT
	e Maryland a-f show	ctor	10a. State 10b. County	Georges	Bowie							10d. Inside City Limits 1 X Yes 2 □ No
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980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Chaelth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Medical Evartical must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Ever in Amed Forces? 1 Tyes 2 No If Yes, Give 41-			nt of Hisp y Cuban,		? (Specify Yes or duerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	within 72 ho lene. than "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+) 5+	(Give life. I	dent's Usual kind of work DO NOT use	done dui retired)	ring most of	working		Kind of Business/I	ndustry
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Place of Dispo- cemetery, crem ne Hill	natory or oth Cemet	erplace) cery		Date 30/2004	Do	ocation - City or T	
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100	Physician bull of the physician and physician and physician and physician and physician site of the physician and	dical Examiner	23a. Partf. Enter the disease, or comp shock, or heart failures. List only of Immediate Cause (Final disease or condition resulting in death) Caquer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	quence of):	er the mode	pot			y arrest,		Approximate Interval Between Onset and Death 3 weeks
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5		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - At h building, etc. (Speci	(y)				City or I	own, State		
	To the Hospitat or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 29a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
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_			30. Name and address of person who co Peter Eckbery MK	14300 6	n 23a) (Type, P allant	rint)	lane	#110	Bowle	, M	0 2011	-5
	Sta Registr		31. Date filed (Month, Day, Year)	32. Istrar's Signa	ature A	داسا						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day 14:30p^M 16 04 Physician Physician Catherine Best /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly

The Vear Hunder 24 Hrs. Min. Prince Georges Prince Georges Hospital Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Ye 8/28/32 If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number Hours **Funeral** 1 □ M 2 🔀 F No Carolina 71 237-36-7091 Director Usual Residence of Decedent 10d. Inside City Limits deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County ral', or Itams 23a or 28a-f ahow Exercises must be nellited at 1 X Yes 2 □ No Landover Prince Georges MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20785 9040 Continental Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X No 72 hours after 1 ☐ Never Married 2 ☐ Married black 1 ☐ Yes 2 ☐XNo Specify Specify: If Yes, Give Year or Dates: Maryland 21215-0036 δ 3 Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) other traumatic avent, the Medical filed within 7 Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) other than Catering/Food 1+ Banquet Coordinator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be d 2 should be fi h end Mental F 7 is marked of Anna Bell POrter Lester Thorne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health er
Important: If item 27 is
any Injury or other trau 9040 Continental Place Landover, MD 20785 Cynthia Brown /daughter 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem. Park 7/23/04 Landover, MD * 4 □ Donation 5 □ Other (Specify) 21. Signatule of Funeral Service Licensee B K Henry Funeral Chapel Inc. 420 H Street NE Washington DC 420 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as e consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, signed by the attending physicien d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 nonths?

1 Yes 2 No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s performed 2 🗆 No 2 No 1 Tyes 1 Yes Division of Vital 26. Place of Death (Check only one) or Attanding Physician: funeral director, To Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) X No Hospital Inpatient 2 ER/Outpatient 3□ DOA 1 Tyes Alter this 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mepner of Death Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident
 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 - Homicide To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Dr.

31. Date filed (Month, Day, Year)

James Catavenis

3 0 2004

3001

Hospital Drive, Cheverly, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Day **Physician** AUGUST 8, DAVID GERALD BUTZ 2004 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min **X**M 2□ F Yrs JANUARÝ 28,1930 230-32-0202 Director 74 OHÍO Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b County 28a-f show other traumatic event, the Mudical Examiner - ust be notified at 1 XXes 2 □ No Director MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 716 YOUNG WAY or Items 23a UNITED STATES death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by WHITE 3 ☐ Widowed 4 ₩ vivorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7/ th and Mental Hygiene. 7 Is markad other than "n College (1-4or 5+) Elementary/Secondary (0-12) MARKETING LOGISTICS MANAGER X-RAY EQUIPMENT MANUF 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ALBERT GEORGE BUTZ ELSIE LOUISE THOMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21117 MD permit. Pages t and 2 st Department of Health and Important: If item 27 Is n any injury or othar traun JESSICA L. BUTZ/DAUGHTER 4600 EMBASSY CIRCLE APT. 201, OWINGS MILLS. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) CARROLL CREMATION 8/9/2004 HAMPSTEAD, MARYLAND 21. Signature of Fundal Service Licensee 22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. WESTMINSTER, MD 21157 pproximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician cantel /Medical Due to (or as a n n uence of) **Examiner** mohesema Sequentially list conditions, if any, sealing to inmodition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner heart failure certificate be executed burial-transit ongestiv Due to (or as a gonsequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 743962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MAUREEN AHN 1130 B BALTIMORE BLVD., WESTMINSTER, MD 21157 31. Date filod (Month, Day, Year) 32. Registrar's Signature State Sparker Registrar AUG 1 3 2004

			1 - For State Registrar	State of Maryland	•	artment of Hertificate of L			Reg. No. 0	04	25873
	Physicia /Medic		Decedent's Name (First, Middle, Last) Jesse	Ray		Bohrer		2. Date of De. Month Aug. 11	Day	4 Year	3. Time of Death 8:10 pm ^M
•	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Death	1	4c. Co	unty of Death	
			32121 Mudlick Road			Little C	rleans		All	egheny	
	Funeral Director		5. Social Security Number 6. Sex 6. Sex	7. Age (In yrs. la	88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird 9/22/1	915	9. Birthp Cour WV	place (State or Foreign ptry)
	od ,		Usual Residence of Decedent	140-00	_						and having O're the con-
	anyla shov	_	10a. State 10b. County		, Town or Lo					,	1 ☐ Yes 2 🔀 No
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	with t	i	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mentalle Hygiene. Important: If tien 27 is marked other than "naturel" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exactifier result by incitied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 🗽 No	spanic Origin? (S n, Mexican, Puert Specify:	pecny Yes of No o Rican, etc.)		Black, White,	
ŏ	2 ho	Completed	15. Decedent's Educat	ion	16a. Deced	dent's Usual Occupa	ation	4.1-	16b. Kind	of Business/In	dustry
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7	od wii	PO.	9		Bı	rakeman			Rai	lroad	-
p	al Hy al Hy vent	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	, Maiden Sui	тате)	
<u>Ja</u>	Ment Ment arkac	2	Arthur Bohrer				Lillian	May Grin	nm		
lan	2 sho and Is ma		19a. Informant's Name/Relationship (Type,	Print)		ng Address (Street a					11.5
≥.	and salth n 27		Teresa L. Mayer			Tellier	Road, Ne				
ore	of Hi of Hi of iter		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Rem	CO	ace of Dispo metery, crer	sition (Name of natory or other place	θ)	Date	20c. Locat	ion - City or To	own, State
Ē	Pag ment ant:		`4 ☐ Donation 5 ☐ Other (Specify)		hel C	emetery	8/14	/2004	Berke	ley Sp	rings WV
Baltimore,	permit. Depart Import any inj pnce.		21. Signature of Funeral Service Licensee	0	Hi Hi	2. Name and Address elsley-Jo	s of Facility	meral Ho	ome. T	nc.	
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6	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence (f):						
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X	ii. 8	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence ot):						
	ate be executed hysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
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×	eath certific attending p for use as	/W	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnar	ncy				230	I. Date of deliv	erv
Вох	feath atte	clai	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)				Month	Day Year
P.O.	that the death cer ed by the attendir detached for use	ysi	9 Unknown	9 Unknown							
	requires that the een signed by th hould be detache	by PI	Part II. Other significant conditions contrib	outing to death but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did 1	tobacco use	contribute to t	the cause of death?
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	To the Hospital or Attanding Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (City or To	Street and N wn, State)	lumber or Rur	al Route Number,
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-	To the Hospital vithin 24 hours a to the Funaral I completely filted	Medicai	29a. Certifier Check only and 2 Medical Examiner	an: To the best of my know On the basis of examinat	viedge, deat ion and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	date and pla	id manner as : ace, and due !	stated. to the cause(s)
	ithin i	Mec	29b.,8tgnature and title of certifier	and manner stated.		29c. License	e number		29d. Date s	signed (Month,	. Day, Year)
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		_	For State Registrar			Cei	tificate (of Dea	ath	- ,		. No.	004	25874
	Physicia	an	Decedent's Name (First, Middle, Last)							1	Date of Death Month	Day	Year	3. Time of Death
	/Medic Examin		James M. Brumba 4a. Facility Name (If not institution, give s				4b. City, Tow	m, or Loca	tion of D		igust	05,	2004 County of Deat	7:30 A. M
	LXaiiiii	3	Broadmore Assiste	d Living			Hager	stow	n			Wa	shingt	on
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. I	ast birthday) 90 Yrs.	If Under 1 Y Months Da		nder 24 l	vin.	Date of Birth Month, Day,)			hplace (State or Foreign ountry)
	Director		184-18-3679 19 Usual Residence of Decedent			90				!Sep	otember i	13,1	913 N	D
arylan	Show	<u></u>	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	28e-f	Director	MD Washingt	on	Ha	ncock	10f. Zip Co	10			100	Citiz	en of What Co	21
with r	38 or		126 Fairview Driv	ρ			21750					USA		
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d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or tems 23e or 28e-f show Important: If item 27 is marked other than "naturel", or tems 23e or 28e-f show any injury or other treumatic svent. If a Modical Examination until be notified at once.	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 TorYes 2 ☐ N If Yes, Give Year or Dates:	lo		Yes 2∑X		ecify:		, ,		Coorifu	lack
Maryland 21215-0036 d 2 should be filed within 72 hours aff	nature Ical E	ted	15. Decedent's Edu (Specify only highest grade	cation		16a. Dece	tent's Usual O	cupation	most of	working	16	Bb. Kin	d of Business/	
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id be	Mental arked c	To Be	Lewis Brumback						E11	a Smi	th			
laryla 2 should	and N Is ma		19a. Informant's Name/Relationship (Ty				· .		lumber o	r Rural Ro	ute Number, (•	Town, State, 2	Zip Code)
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Baltimore, permit. Pages 1 ac	ant of I it: If it y or o		1 Surial 2 Cremation 3 R	emoval from State	a	emetery, crer	natory or other	place)			. 16-		200	Town, State
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Division of Vital Records,	tificate tor, pa	Be Co	25. Was case referred to medical					26.	Place of	· · · · ·	1 ☐ Yes 2 〔 eck only one		1 🗆 Yes	2□ No
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riSiC Attend	death ctor: y the	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 Yes 2 N 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							2 🗆 140	28f. l	_ocation_(Stre	et and	Number or Ru	ıral Route Number,
= 5	2.5 €	Cert	4 Homicide determined	building, et	c. (Specify	Y)					City or Town,	State)		
Hospitel	within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	ner: On the basis of	examina	wledge, deatl tion and/or in	n occurred at the	ne time, da my opinion	ate and p	lace, and o	due to the cau the time, dat	se(s) a e and p	and manner as place, and due	stated. to the cause(s)
o the	o the	Med	29b. Signature and title of certifier	and manner sta	ited.		29c. Li	cense num	nber		290	i. Date	signed (Monti	h, Day, Year)
F	> ⊢ ŏ		FB themes	TI m	19			D001	223	7	0	8/0	06/200	4
	1		30. Name and address of person who co	empleted cause of d										The state of the s
	-04		Frank B Thomas,	III, M.			onolo	way	Han	cock	, MD	217	/50	
	Sta Regist		AUG 1 8 2		position		10	uli	1					

				State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N 1- State of Maryland / Department of Health and N	nentai my	Reg. N	2 H H I I I I I I I I I I I I I I I I I	25875
		Dhysisi		1. Decedent's Name (First, Middle, Last)	2. Date of D Month		Day Year	3. Time of Death
_		Physicia /Medic		Beatrice H. Brown			2004	19:44 M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4	4c. County of Deat	h
	Ţ,			Southern Maryland Hospital Clinton			P.G.	
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of B. (Month, D	irth ay, Yea	9. Birti	nplace (State or Foreign untry)
	\mathbf{v}_i	Director		234-98-0042	2/11/	19.	33 MD	
		land		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
		Mary	ğ	MD P.G. Forestville				1∭2Yes 2 ☐ No
		with the Maryland a or 28a-f ahow be notified at	rec	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Co	untry?
		3a ou	<u>=</u>	2405 Boones Lane 20747		T	J.S.A.	
		ours after death v ral', or Items 23a Eraniner must	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or N		14. Race - Ame Black, White	ncan Indian,
	9	after or Ite		1 Never Married 2 Married 1 Yes, Give 1 Yes 2 No Specify:	rican, etc.,			
	215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ahow he Medical Examiner must be notified at	Completed by	Year or Dates:				Lack
7	5-(thin 72 ho e. an "natu Medical	ete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	16b.	Kind of Business/	Industry
7	2	within piene. r than	μ	Elementary/Secondary (0-12) College (1-4or 5+)				
13	121	led lygi her nt,		10 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First Middle	e. Maide	Privat	;e
@	ano	0 = 0 ×	Be c				,	
3	Maryland	12 should be fi h and Mental H 7 la marked ot traumatic aver	ို	William Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		ber, City	y or Town, State, Z	lip Code)
7	Z	nd 2 s		Yvonne Brown/daughter 2405 Boones Ln. Fo	restv	111	e.Md.20	1747
10	ē,	ges 1 and 2 should b t of Health and Ment If item 27 Ia marked or other traumatic a		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		Location - City or	
128/64	altimore,	permit. Pages Department of I Important: If it any injury or o			3/04	C1	inton,N	ID.
1/2	===	permit. I Departm Importar any injur		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HO	daes a	and	Edward	S
3	m	E E E E		Janice Edwards per DVR 3910 Silver Hi				
		3		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory	arrest,		Approximate Interval Between
		Physician	2 15	Immediate Cause (Final disease or condition CEREBROVASCULAR ACCIDENT				Onset and Death
U		/Medical		resulting in death) Due to (or as a consequence of):				
21		Examiner		Sequentially list conditions, b. CONGESTIVE HEART FAILURG				
8		sit sd	juer	cause. Enter Underlying	DICE			
3	1	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	VIJER	· > C		
2	90	be ey ician buria						
1	687	ificate be executed g physician and as the burial-transit	edical	d				
	Box (lan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	very
)	B	The faw requires that the death certate has been signed by the attending page 2 should be detached for use	clai	in the past 12 months? 1			Month	Day Year
3	0	tt the de by the a tached	Physic	9 ☐ Unknown 9☐ Unknown				
	ď.	res tha ign e d l be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco	o use contribute to	the cause of death?
t	rd	w require been sig should b	73	ATRIAL FIBRILLATION	1 🗆	Yes	2 □ No 3 □ Pro	obably 4 Munknown
eatri	Records,	e faw requ has been ge 2 shoul	ompleted		24a. Wa	s an		topsy findings available completion of cause of
2		sician: The certificate hir	Com			ormed?	death?	2 No
1	Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	th (Check only	one)		
1	of V	Physic this corral dire	ပို	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho			6 ☐Other (Spec	sify)
ROWN	n o	ding P. h. After t funera	on:	27. Manner of Death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28d. Describe	how in	jury occurred	
0	sio	Attender death sector: /	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 399 Place of Injury. At home farm, street, factors office	20f Location	/Street	and Number or Ru	m / Pouto Number
S	Division	or Atlanta	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To			rai noute railiber,
(3)		pital	0	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	e cause	(s) and manner as	stated.
		To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely illied in by the funeral director.	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur one)				
		To th within To th	Me	29b. Signature and title of certifier 29c. License number		29d. [Date signed (Month	n, Day, Year)
				D 52900		07	-29-20	104
		3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUSA MOMOH MD 8700 CENTRAL AV. H301,	LAND	DV G	R MD	20785
		Sta Regist		31. Date filed (Month, Day, Year) AUG 1 8 2004 AUG 2 8 2004 AUG 2 8 2004				

UNK	04-255	i icasc i	The of the mediate man Endarge me copies the	;
MHW	ERNEST H.	BANNISTER JR.	State of Maryland / Department of Health and Mental Hygiene)

Dhusis		Registrar #23a-b,27, 1. Decedent's Name (First, Middle, Las			JULY 23	Day OO 4 Year	3. Time of Death						
Physicia /Medic	a!	Ernest H	Bannister , Jr.	dt. Cit. Turn out outline at Don		4c. County of Death	3:35 P						
Examin	er	4a. Facility Name (If not institution, give 5381 SANDS RD	street and number)	4b. City, Town, or Location of Deal LOTHIAN	п		UNDEL CO						
Funeral Director		579-52-9696	7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You March 9,	(ear) 1942 Was	place (State or Forei pity) hington,						
Mo til	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location			10d. Inside City Limi						
e-f sh	ctor	MD Prince G	eorge's Mitch	nellville			1 □ Yes 2 1						
or 28	Dire	10e. Street and Number		10f. Zip Code		. Citizen of What Cou	intry?						
s 23a	era	11400 Waesche Dr.	12. Was Decedent Ever in U.S.	20721	Opecify Yes or No-	DA 14. Race - Ameri	ican Indian.						
ital Hygiene. ad other then "neturel", or Items 23a or 28e-f show event, I'le Nezical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Mamed 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☼ No Specify:	to Rican, etc.)	Black, White	, etc.						
neture Jical E	eted	15. Decedent's Ed		Decedent's Usual Occupation (Give kind of work done during most of wo	rking 16	b. Kind of Business/Ir	ndustry						
then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`lite. DO NOT use retired) Engineer		Priv	ate						
Hygie other ent, II		17. Father's Name (First, Middle, Last)	2+	· · · · · · · · · · · · · · · · · · ·	me (First, Middle, Ma								
rked c	To Be	Ernest Hawthrone	Bannister, Sr.	Ruth	Slaugh	hter							
f Health and Mental Hygiene. Item 27 is marked other then " other treumatic event, I'm Ms.		19a. Informant's Name/Relationship (Type, Print) Ruth S. Bannister/ Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11400 Waesche Dr. Mitchellville, MD 20721 20b. Place of Disposition (Name of comparison or other place) 20b. Place of Disposition (Name of comparison or other place)											
of Health filtern 27 r other tr		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State											
ment o tent: If lury or		*4 Donation 5 Other (Specify) Riverdale Crematory 8/7/2004 Riverdale											
Department of the Importent: If Ite any injury or of one one of o		21. Signature of Funeral Service Licen	achsin	22. Name and Address of Facility J. 7474 Landover Rd.	_	r, MD 2078							
		23a. Part . Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arrest	t,	Approximate Interval Between Onset and Death						
ysician		Immediate Cause (Final disease or condition resulting in death)	a. Coronary Thro				0.1001 0.10 0000						
Medical aminer		resulting in death) Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease											
	Jer	Sequentially list conditions, if any, lauding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or us a consequence										
nd ransit	amlr	Cause (Disease or injury that initiated events											
ig physiclan and as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a consequence	ot):									
ling ph e as th		IF FEMALE:	Office Indiana and an arrangement										
ed by the attendin detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of deli-	very Day Year						
n signed by	by	Part II. Other significant conditions of	ontributing to death but not resulting	in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?						
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			24a. Was an autopsy performe	prior to o	opsy findings availa ompletion of cause of								
certificate rector, pag	O	25. Was case referred to medical		26. Place of De	ath (Check only one)	140 /2.00							
.∞ '0	To B	examiner? 1∑Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3 DOA Cther: 4 Nursing Time of Injury Use 1 Nursing 28c. Injury at Work?	Home 5 Residen	ce 6XXOther (Spec	ify) SCENE						
within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	injury occurred										
within 24 hours after death To the Funeral Director: completely filled in by the	Sertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, the building, etc. (Specify)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru. State)	ral Route Number,						
24 hours e Funere etely fille	Medical (29a. Certifier (Check only one)	ysician: To the best of my knowledg niner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occ	e, and due to the cau urred at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)						
ithin o th ompl	Me	29b. Signature and title of certifier	s I	29c. License number	290	d. Date signed (Month							
3 ⊢ ŏ			N (W) ()	OCME		JULY 24,	2004						
within 2 To the	_	Mallinte 1	no Unill	3 3 11 2		0022 21,							

Registrar

AUG 1 1 2004 Blown & Sparke

	1	For State Registrar	State of M	aryland	-	artmen tificat				F	leg. Ng	004	2587	
Physician /Medical Examiner	1	le. Facility Name (If not institution, g	land Crawl			4b. City,		Location of		2. Date of Dea Month July	25 ^{Day}	2004		
Funeral Director		579-24-2738		ge (In yrs. Ia	ast birthday) Yrs.	If Under Months		urel If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Nov • 2	1	9. Birth	George's place (State or Fore intry) ash., DC	
Ba-f show			George's	10c. City	, Town or Lo]	Laure	e1					10d. Inside City Lim 1 Yes 2 ☐ I	
after death with the Ma or Items 23a or 28a-f s niner must be notified Funeral Director	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	10e. Street and Number 14030 Briary				10f. Zip		2070			Ţ	en of What Cou Jnited	States	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. "natural", or items 23s or 28s-f show other traumatic event, the Mardical Examiner must be notified at The Re-Commission by Figure 1 Director	oy rune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yes 2 4 If Yes, Give Year or Dates:	?	- 1	Was Deced If Yes, spec 1 Yes		spanic Ori n, Mexicar Specify:		cify Yes or No- Rican, etc.)	1	4. Race - Amer Black, White Specify: B		
ee filed within 72 hours all Hygiene. I the than "natural", covert, the Muchan Exer	ompieted	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) College (1-4or	5+)	(Give	dent's Usua kind of wo DO NOT u	rk done d se retired	turing mos	t of workin	ng	16b. Kind	d of Business/I Gover	,	
2 should be filed and Mental Hyg ls markad other raumatic evant,	e a	12th Painter Gove 17. Father's Name (First, Middle, Last) Alfred Crawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State												
nd 2 shoralth and N 27 Is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta Naomi O'Neal - Daughter 14030 Briarwood Dr., Laurel, MD 207 20a. Method of Disposition (Name of Date 20c. Location : City										Town, State, Z 20708	ip Code)	
permit. Pages 1 and 2 Department of Health s Important: If item 27 ts any injury or other tra once.		Naomi O'Neal - Daughter 14030 Briarwood Dr. 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 14030 Briarwood Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park 7/:									own, State MD			
permit. Departmit. Importa any inju		21. Signature of Fineral Service Li 23a. Part 1 Enter the disease, or c shock, or heart failure. List or	Slewrout	TIL	1	4001	Ben	ning	Rd.	Stewart Funeral Home				
e be	lical Examiner	Immediate Zause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Seps	sis saconsequ lio Va	uence of): uence of): uscula	r Acc	iden	t				JII.		
that the death certificated by the attending phydetached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	I death 3	⊒Ectopic p ⊒ Other (s _i		,			2	3d. Date of deli Month	very Day Year	
w requires that been signed b should be deta	ed by Pr	Part II. Other significant condition Di	s contributing to death		ulting in the	underlying	cause giv	en in Part	l. 	1	obacco us Yes 2		the cause of death?	
sician: The law requires the certificate has been signe rector, page 2 should be	Complet		pertension nal Failure	e								prior to death?	topsy findings availa completion of cause 2 No	
hysician his certilit	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigit	Hospital: 1 V Inpa 28a. Date of In (Month, L	tient 2	ER/Outpatie 28b. Time Injury		28c. Injui Wo	er: 4 N	ursing Hor	n <i>(Check only o</i> me 5 ☐ Resi 28d. De <i>s</i> cribe	dence 6	Other (Spec	cify)	
itel or Atte	Certification:	3 Suicide 6 Could n 4 Homicide determin	building,	etc." (Specif	(y)					City or To	wn, State)		ral Route Number,	
the Hosp in 24 hou the Fune	Medical	(Check only 2 Medical E	Physician: To the be- xaminer: On the basis and manner:	of examina	owledge, dea ation and/or i	nvestigation	n, in my (pinion, de	nd place, ath occurr	and due to the ed at the time,	date and	place, and due	to the cause(s)	
CO (E)	2	29b. Signature arguitle of certifler Society 30. Name and address of person w	MO AHO	f death (Iter	n 23a) (Type	a, Print)		D-425		""		signed (Mont July 26	5, 2004	
Stat Registra			Auila, M.	D. 5	632 Ar	napol	is F	Rd.,	Suite	#13,	31ade	nsburg	, MD 20	

DHMH 17 Rev 1/2001

ABERTO CRAWLEY 11-23-1813 MR # 50 375483.

Edward Willis Carey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-4858 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar **AKG** Reg. No. Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day **Physician** Edward Willis Carey July 26, 2004 11:05 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth May 28, 1962 9. Birthplace (State or Foreign Wash., DC 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ xM 2 □ F 42 231-90-7356 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYes 2 No Capitol Heights Director Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 5 20743 United States 1600 Dewitt Avenue Items 23a 2 should be filed within 72 hours after death and Mental Hygiene. Is marked other then "naturel", or Items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) $\stackrel{\text{Elementary/Secondary } (0\text{-}12)}{12\text{th}}$ College (1-4or 5+) Roofing Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Shirley George Walter Carter Carey, Jr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s nent of Health an t of Health If item 27 I 1600 Dewitt Ave., Capitol Heights, MD Shirley E. Carey - Mother other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ŏ Department of Importent: If eny injury or once. 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemetery 7/31/2004 Brentwood, MD 21. Sign ture of Runeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home wou 4001 Benning Rd., N.E. Wash., DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final unshot wound Pnysician disease or condition resulting in death) /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury Dise to (or as a consectional off: Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ pe 1 Tes 2 No 3 ☐ Probably 4 ☐Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Xes 2 No 2 No Hospitel or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XXYes 2 No this 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation subject 1 Natural Sno 1 ☐ Yes 2 XNo -26-04 death. 2 Accident after death Director: 28e. Place of Injury - At home, farm, street, factory, office determined

28f. Location (Street and Number; Rural Route Number, City or Town, State)

City or Town, State)

City or Town, State)

City or Town, State)

City or Town, State)

Manner as stated.

My Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Suicide Homicide 3 MD 29a. Certifier Medical (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0

CP (3)

State Registrar

trar JUL 3 0 2004

and address of person who completed cause

Registrar's Signature

Response France Response

death (Item 23a) (Type, Print)

O.C.M.E.

July 27, 2004

			1 - For Stete Registrar	State of	Marylan		artmen rtificate			and M	-	giene Reg. No.	004	25879		
	Physici /Medic		1. Decedent's Name (First, Middle, Coreen Crews	,							2. Date of Dea Month 07	Day	Year 2004	3. Time of Death 3:05 A ^M		
į	Examin		4a. Facility Name (If not institution,	give street and numb	er)		1		Location of			4c. C	ounty of Death	1		
			Holy Cross H		- "		Silv		Spri	_	MD		ntgom		_	
	Funeral Director		578-34-5546	6. Sex 7. 1 □ M 2/□XF	Age (In yrs.	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt Month, Da 03/18	y Year) 124	Re e	place (State or Foreign intry) evesville		
	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits	-	
	Mary 1sh	ţō	MD PG Co	unty	0x0	n Hil	.1							1 XYes 2 No		
	with the	Il Direc	10e. Street and Number 6482 Bock Roa	d			10f. Zip					10g. Citize	en of What Cou	untry?		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28s-f show any injury or other traumatic event, If a Modical Eracing fruits fruits of an once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ∑ No		Was Deced If Yes, spec	ify Cuba	spanic Ori n, Mexican Specify:	gin? (Spe	ecify Yes or No Rican, etc.)		Black, White			
21215-0036	within 72 ho ane. than "natur e Medical	mpleted	15. Decedent (Specify only highes: Elementary/Secondary (0-12)	s Education t grade completed) College (1-4	or 5+)	(Give	dent's Usua kind of wor DO NOT us	nk done d se retired	du <i>rina m</i> osi	t of worki	ing	16b. Kind	d of Business/li	ndustry		
land 2	uld be filed Aental Hygie rkad othar tic evant, U	To Be Co	17. Father's Name (First, Middle, Last) Jeff Jakes 18. Mother's Na Estel.									Maiden S	'umame)			
Maryland	nd 2 shou alth and N 27 Is ma		19a. Informant's Name/Relationsh Theodore Crew	re Ft.	ip Code) 20744 on, MD											
Baltimore,	Pages 1 a lent of Hes nt: If itam ry or otha	120	20a. Method of Disposition 1			Place of Dispo cemetery, crea urre	matory or o	ther plac	mete		0ate 7 / 2 7 / 0	te 20c. Location - City or Town, State /27/04 Clinton, MD				
Balti	permit. Departm Imports any inju		21. Signature of Funda Service L	Laule	N	- 10	2. Name an . 7 2 2				aylor' tol St			Home WDC 2000	1	
8760,	death certificate be executed Medical Examine and physician and dior use as the burial-transit	ilcal Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of the shock of heart failure. List of the shock of heart failure. List of the shock	a. Due to (or Due to (or c.	r as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a conse	uence of):	ter the mod	e of dyin	g, such as		or respiratory ar	rest,		Approximate Interval Between Onset and Death		
.O. Box 6	death certific e attending p id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 9 ☐ Unknown		th 2 ☐ Feta nt at time of c	il death 3	⊒Ectopic pr ⊒ Other (sp		_			23	d. Date of deliving	very Day Year		
٥	w requires that the been signed by th should be detache	by	Part II. Other significant condition	ns contributing to dea	th but not res	ulting in the u	underlying c	ause give	en in Part I			obacco use res 2 🗆		the cause of death?		
Vital Records,	The law ate has b page 2 sl	Completed									24a. Was autop perfo 1 Yes		24b. Were aut prior to codeath?	opsy findings available ompletion of cause of		
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:	_			Oth		-	(Check only o				_	
of	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of (Month,		ER/Outpatie 28b. Time o Injury		8c. Injury Worl	/ at k?		me 5 Resid 28d. Describe h			ify)		
Division	or At fter o Dirac in by	ertification;	3 Suicide 6 Could reduced determine	ined 286. Place 0	f Injury - At h g, etc. <i>(Speci</i> i		M 1 □ Yes 2 □ No 1. street, factory, office 28f. Location (Stree City or Town, S						Number or Rui	ral Route Number,	Ī	
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	edical C	29a. Certifier 1 Certifyin (Check only one) Medical I	g Physician: To the b Exeminer: On the bas and manne	is of examina	owledge, deat ation and/or in	th occurred exestigation	at the tim	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)		
	To th To th Comp	×	29b. Signature and title of certifier				290	. License	e number			29d. Date	signed (Month	, Day, Year)		
			1 1	LE, C	ONNIE			D60	0619			71	22/04			
R	(3)		30. Name and address of person of Connie Le -					Sil	Lver	Spr	ing, M	id. 2	20910			
••	St Regist	ate rar	31. Date filed (Month, Day, Year) JUL 2 6 20		gistrar's Signa	ature Los	W		,							

						•	tificate		Death		Reg. No. ()	14 2	5880		
	Physicia	n	1. Decedent's Name (First, Middle, Las Ruth Civ							2. Date of De Month	Day	Year -	Time of Death		
٧,	/Medica Examine	_	4a Facility Name (If not institution, give					Τ.	4b. City, Town, or L	July July ocetion of Deat	24 , 2 h 4c. County	004			
			Montgomery Gene	ral Hospi	tal				01ney			ntgomer	У		
	Funeral Director		336-30-4109	x 7. Ag □M 25xF	je (in yrs.	last birthday) 75 Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De June 2	8. Date of Birth (Month, Day, Year) June 23, 1929 9. Birthplace (State or Foreign Country) Peru				
	how		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation						nside City Limits		
	with the Meryland to 28a-f show	ᅙᇶᆝ	Maryland Montgome	ry	Wh	neaton							Yes 2□No		
	h with the	a Dire	10e. Street and Number 2424 Eccleston St	reet			10f. Zip 0	902			10g. Citizen of V	What Country? d State			
020	within 72 hours after death with the Meryland sne. than "natural", or Itams 23a or 28a-f show the Medical Examinar must be redified at	Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U				lispanic Origin? (Sp an, Mexican, Puerto Specify: Per		Bla	ce - American Ir ck, White, etc. v: Spani			
Maryland 21215-0020	within 72 ho ene. than "naturi he wedical	ompleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucetion de completed) College (1-4or	5+)		16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) Housewife		ation furing most of working)		16b. Kind of Business/Industry Domestic		у		
nd 2	ies 1 and 2 should be filed within of Health and Mental Hygiene. I flem 27 is merked other than it other traumatic event, the Mr.	မှ ရ	12th 17. Father's Name (First, Middle, Last)			House			18. Mother's Nam		, Maiden Suman				
ıryla	marked	2	Theodore Zegarra Petrolonila Vernal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State,										(a)		
, Ma	end 2 sauth en 27 is i		Marlene Ciuffardi/Daughter 365 Elkdale Road, Lincoln, Pa. 19352												
Baltimore,	permit. Pages 1 end 2 Department of Health e Important: If Item 27 is any Injury or other tra once.	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)									Date 20c. Location - City or Town, State 2/28/04 Silver Spring, 1				
Balt	permit. Page Department o Important: If: any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility 24 Donation 5 Other (Specify) 25 Pope Funeral Homes 5538 Marlboro Pike Forestville, MD.												
	Physician //wedical Examiner	10	23a. Part1 Enter the disease of comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	_{a.} Respii	ator	y Failu oras a consequ	ire ience of):					Inte Ons	proximate rval Between set and Death		
Box 68760,	÷ 0,0	redical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cd.	structa or as a consequ r as a consequ	ence of):	11mc	onary Dis	ease						
	death e ette	SICIA	Part II. Other significent conditions co	ntributing to death b	ut not resi	ulting in the un	derlying cau	ıse giv	en in Part I.	23b. Did	tobecco use co	ntribute to the	cause of death?		
s, P.O	v requires that the death cer been signed by the ettendin should be detached for use	y ruy	Parkinson's Disea	ise						10	Yes 2□ No	3 ☐ Probably	4 Unknown		
Records,	law require es been sig	Completed by Physiciann	Hypertension			24a. Was	an autopsy ormed?	availab	utopsy findings le prior to tion of cause 1?						
	The law sete hes page 2	0								10	Yes 2 No	1 ☐ Ye	s 2□No		
Vita	Physician: The this certificate ral director, pag		25. Was case referred to medical examiner?	Hospital:				Oth	26. Place of Deat						
ō	P Sign		1 ☐ Yes 2 No 27. Manner of Death	28a, Date of Inju	ry	ER/Outpatient 28b. Time of		c. Injur	4 LI Nursing Ho		dence 6 ⊡Oth how injury occur				
Division of Vital	Attending Physical death.	Certification	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide	(Month, Da 28e. Place of Inj building, et	urv - At ho	Injury	М	1 🗆	Yes 2□No	28f. Location (Street and Numb	er or Rural Ro	ute Number,		
۵	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical cer	(Check only 2 Medical Exemi	sician: To the best ner: On the basis o	of my kno	wledge, death	occurrad at	the tin	ne, date and place, pinion, death occurr	and due to the	cause(s) and ma	anner as stated	cause(s)		
,	the lithin 2 the limplet	Med	one) 29b. Signature and title of certifier	and manner st	ated.		29c	Licens	e number		29d. Date signe	d (Month. Dav	Year)		
	FEFS -		1 Celmons	: Lul	(ren	ng	j		56691		7/21	PAL	-		
	CR (2)		30. Name and address of person who c					_ =				1.07			
	State	, ,	Ghousia Sultan 31. Date filed (Month, Day, Year) 11. 9 7 2004	a, M.D. 1			ge Pa	rk_	Circle, S	Silver S	Spring,	MD. 20)906		

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland /	•	rtment of H			ene	25001			
	Physici		Decedent's Name (First, Middle, Last) Joseph L. C	oleman				2. Date of Death Month July	Day Year 27 2004	3. Time of Death			
}	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. Cîty, Town, or	Location of Death		4c. County of Death				
			Washington Adv				koma Par		Montgo				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		te of Birth 9. Birthplace (State or Foreign Country)				
	Director		230-40-2948 X	^{M 2□F} 68	Yrs.			April 12					
	land bw		10a. State 10b. County	10c. City, To	own or Loca	ation				10d. Inside City Limits			
	Mary 1 sh	ţo	Maryland Montgom	arv		C 1 1 170	n Coninc			1 XYes 2 No			
	r 28e	rec	10e. Street and Number	CIY		10f. Zip Code	r Spring	10	g. Citizen of What Co	untry?			
	h with	by Funeral Director	524 Thayer Av	e., #204			20910		United	States			
	eme 3	ner	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of H	ispanic Origin? (S in, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White	ncan Indian,			
9	or it	J.	1 Never Married 2 Married	1 ☐ Yes 2 🛣 No If Yes, Give		⊒Yes 2. XINo				ack			
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-f show fra Maulcal Examiner i ust be notified at	d b	3 XWidowed 4 ☐ Divorced	Year or Dates:									
<u> </u>	n 72	Completed	15. Decedent's Educ- (Specify only highest grade	completed)	(Give ki	int's Usual Occupi ind of work done o O NOT use retired	during most of wor	king	6b. Kind of Business/l	industry			
7	with iene. ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)			Engineer		Gover	nment			
ğ	filled I Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	faiden Sumame)				
Maryland	uld be Menta rked tic ex	To B	Edward Colema	n				Pauli	ne Brown				
ar	and N		19a. Informant's Name/Relationship (Typ	e, Print) 1	19b. Mailing	Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Z	ip Code)			
≥ ~	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or iteme 23e or 28e-1 show amy highly or other treumatic event, the Masifical Examinet rough to notified at ance.		Tracy Coleman -				ng Bear	The second secon	sville, MD				
Baltimore,	ges 1 I of H if ite		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re		etery, crema	ition (Name of atory or other plac	e)	Date 2	20c. Location - City or 1	Town, State			
≣	Pa tmen tent: jury		* 4 □ Donation 5 □ Other (Specify)	Lee	e's C	rematory			Clinton				
Ba	Depar Mpor mpor mpor png in		21. Signature of Funeral Service License	111	22.	Name and Addres	5		neral Home				
	45244		23a. Part1 Enter the disease, or complic	ations that caused the death.	Do not enter			N.E. W		20019 Approximate			
8760,	/Medical Examiner (Me portial-transit provided the provi	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ce of):	wn_				Onset and Death			
P.O. Box 687	t the death certific by the attending p	Physiclan/Medic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de. 4 Pregnant at time of death 9 Unknown	ath 3 ☐ E	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year			
	res tha igned l	by	Part II. Other significant conditions cont	ributing to death but not resultin	ig in the und	derlying cause give	en in Part/h		acco use contribute to				
ecords,	law requires as been sign 2 should be	eted	Gongedine	reampa	LLe.	-1 re	nal	1 110	s 2□No 3□Pro	bably 4 🗷 Unknown			
Œ	he his	Completed	tactive,	alles O	cul	eng/	leopu	Ja. Was ar autopsy perform	/ prior to c	topsy findings available completion of cause of 2 No			
Vita	icien: T	BeC	25. s ase referred to medical examiner?		Sy	Va	26. Place of Dea	th (Check only one		20.10			
of <	d s	2	1 ☐ Yes 2 ☑ No	ospital: 1 ☑Inpatient 2 ☐ ER/	/Outpatient	3 DOA Oth	er: 4 🗌 Nursing H	ome 5 🗆 Reside	nce 6 Other (Spec	ufy)			
ت ت		e .:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injun Work	y at k?	28d. Describe ho	w injury occurred				
<u>s</u>	Attending r death, ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No						
Division	or At after of Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		City or Town,	eet and Number or Ru State)	ral Houte Number,			
_	To the Hospitei or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	ician: To the best of my knowler er: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)			
	To the vithin 2 To the comple	Me	29b. Signature and title of certifier	. 0 -	7.	29c. License	e number	29	d. Date signed (Month	, Day, Year)			
			Sean	malila	lon	(d	7953	2	1/27/0	24			
	0 12)	30. Name and address of person who cor	npleted cause of death (Item 23			. // .			20912			
	10		31. Date liled (Month, Day, Year)	WHITE	760	O CARI	CO11 AV	E. TAI	KOMA PA	RK/H.			
	Sta Regist	ate rar	JUL 3 0 2004	Aller K	bon	r .							

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day}2004 July 22, **Physician** Charles Crawford, Sr. 7:40a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince Georges Community Hospital Cheverly Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 17, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**₹**M 2□ F 1918 Washington, D.C. 577-12-6273 86 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-1 show the Medical Examiner must be coulded at 1 Z¥Yes 2 No Directo Maryland Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 6010 Belwood Street United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Painter Private permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any jury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Josephine Martin Robert Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 Walker Mill Rd. Capitol Heights, Md. Veronica Young / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State July 29,2004Landover, Md. Harmony Memorial * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Mariboro Pike/forestville, Md. 21. Signature of Funeral Service License 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a conseque Examiner one 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physicien a detached for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 Probably as been si Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy page 2□ No 1 ☐ Yes 2 No 1 Tyes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident in by the Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 303/6 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Catevenis, M.D. 3001 Hospital Dr. Cheverly, Md. 20784 31. Date filed (Month, Day, Year) Registrar's Signature State 2 7 2004

DHMH 17 Rev 1/2001

Registra

	ian	Registrar AT	merrol # 26. ne (First, Middle, La	Per Phys. P ast)	GC cr	Cei	runcate	of Deal		2. Date of De	Reg. No. ath Day		3. Time of Death	
/Med			MURRAY O							July 1	7, 2	2004	7:09 PM M	
Exami	ner		(If not institution, git Llentown	ve street and numbe	er)			Town, or Location			1 _	County of D		
Funera		5. Social Security			Age (In yrs.	last birthday)	If Under 1		ler 24 Hrs.	8. Date of Bin	th		Birthplace (State or Foreign Country)	
Director		190-34-3 Usual Residence	of Decedent	1 X M 2□F	59 yr		Months	Days Hour	s Min.	April 2	y, Year)	945 W	ilmington, N	
Marylar f show	tor	10a. State	10b. County Allegha	ny		y, Town or Lo Ladelph		a.				10d. Inside City Limits 1 Yes 2 □ No		
or 28a	Director	10e. Street and N					10f. Zip (10g. Citi	zen of What	Country?	
s 23s			egheny Av	e Apt 202		0 110		133	0-1-1-0-10	7 7 7		ISA		
d within 72 hours after death with the Maryland plene. I than "netural", or Items 23s or 28s-f show Its Medical Exertine fromst be redified at	by Funeral		rried 2□ Married 4 汉 Divorced	12. Was Deceder Armed Force 1 Yes If Yes, Give Year or Date:	s? X No		was Decede If Yes, speci 1 ☐ Yes 2			ecify Yes or No Rican, etc.)	or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: 31ack			
5 9	Completed	(Spe	15. Decedent's E	Education rade completed) College (1-40	or 5+)	(Give	dent's Usual kind of work DO NOT use	done durina n	ost of work	sing	16b. Ki	nd of Busine		
filed withi Hygiene. other than	Con			5 +		Couns	selor					t Ind	ustry	
ld be ental ked c	o Be		(First, Middle, Las Albert Co				18. Mother's Name (First, Middle, Maiden Sumame) Thelma Davis							
and and and and and and and and and and		19a. Informant's i	Name/Relationship	(Type, Print) Sister			•			al Route Number				
os 1 and 2 of Health item 27 I		20a. Method of Di	sposition		_	Place of Dispo	osition (Name	e of		Date	20c. Lo	cation - City	or Town, State	
Page ment clant: If			2 □ Cremation 3 L 5 □ Other (Spec	□Removal from Sta eify)	te	rmony (July	7 23, 20			heriff Rd leasant, MD	
permit. Pages i Department of h Important: If ite any injury or ot once.) Th	funeral Service Lice	Bell Samplications that caus	ė.			Address of Fa	Be	ell Fune	eral	Home		
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icate be executed by physician and sthe burial-transit	al Examiner	resulting in death Sequentially list to cause. Enter Unc Cause (Disease to that initiated even resulting in death)	conditions, immediate derlying or injury ts	b. — Due to (or a	as a consequal as a consequence as a consequen	uence of):	PN	eck.	Car	JEEV.			Interval Between Onset and Death	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** CLAYTON CATHERINE 11:16 PM 2004 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 1 F 63 218-38-8360 Director August 29 1940 Washington, DC Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner rount be notified at 1 TX Yes 2 □ No Funeral Director MD Prince George's Lanham the 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code U.S.A. 20706 3008 Brightseat Road # 103 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural". the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 127 is marked other than "traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) Custodian Engineer Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be nt of Health and Mental H

I: If item 27 is marked oth

or other traumatic even Catherine Henson Joseph Clayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7208 Joplin St. Capital Heights, Maryland 20743 Anita Butler/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 StBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any njury or once. 7/30/2004 Landover, Maryland * 4 □ Donation 5 □ Other (Specify) Harmony Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home K-D. ans 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis DAYS /Medical Due to (or as a consequence of) **Examiner** Post Obstration neumonia DAYS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Me The law requires that the death certificate be executed burial-transit Un. Years Exam Due to (or as a consequence of) Box 68760, physician YRavs and CARCINOMO Physician/Medical Neck the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. the a 9☐ Unknown δ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 1 Yes 1 TYAS Hospital or Attending Physician: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To Alter this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. 1 Tes 2 No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only onel 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00052865 Lel mplet cause of death (Item 23a) (Type, Print) 30. Name of address of person. 7202 Wisin berry Way Bawie 3720

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1552 26 GLORIA Umberhal 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nosp Silver ManTromer HOLY Cross If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth (Month Day, Year) 6-11-45 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1□M 21 F Months Days Hours Min. Panama 59 Yrs. 056-44-2832 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examiner must be notified at WASH. EVERET 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 75th Place S.W. Items 23a 98203 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Marr 3 Widowed 4 Divorced 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black tanamanian "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) than " Elementary/Secondary (0-12) President Of Tenant Control Dept Of Housing 12 should be filed v h and Mental Hygie 7 is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martin Bartley Etheleen Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl nent of Health an ant: If item 27 is n Lawrence Cumberbatch/son 11817 Sylva DR., Clinton, MD., 20735 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cypress Hill 8/3/04 Queens, New York 22. Name and Address of Facility B. K. HENRY FUNERAL HOME 21. Signatur of Funeral Servi / L 420 H Street NE., Wash., DC., 20002 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) monar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed burial-transi nding physician and resulting in death) Last Due to (or as a consequence Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.O. P ed by the a detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ate has been signed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner?

12 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only onel Fo the nature and title of certifien 29c. License number 29d, Date signed (Month, Day, Year) D00428 erm DomE

Registrar DHMH 17 Rev 1/2001

State

mo Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER

31. Date filed (Month, Day, Year)

JUL 3 0 2004

2101 medical

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Connie F. Coleman 24 July 2004 5:05 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Feb. 20, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F 227-30-8303 Virginia Director Usual Residence of Decedent filed within 72 hours efter death with the Merylend 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show f Health end Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-1 shoo other traumatic event, the Medical Examiner must be notified at 1XX Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 - 16th St., N.E. #1 20002 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Black Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Clerical Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 end 2 should be 1 nent of Health end Mentai I Hunter M. Coleman Mary E. Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles M. Coleman, Sr./Brother 300 - 35th St., N.E. Wash., DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 7/30/04 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC rocer Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Metastatic Liver Cancer Examiner Due to (or as a consequence of): Examiner physicien end s the buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): es ettending for use es signed by the eld d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown δ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has been s irector, page 2 should 24a. Was an autopsy 1 Yes 25 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: funerei director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 _ Inpatient 2 _ ER/Outpatient 3 _ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo edical Certification: To After this 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054566 July 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitha Bhogaville, M.E. 1220 E. Joppa Rd., Suite 230, Towson, MD 31. Date filed (Month, Day, Year) . Registrar's Signature State JUL 3 0 2004 Registrar

DHMH 16 Rev 6/95

			For State Registrar		ryland / Depa <i>Cei</i>	artment of I		F	10g. Ng. 0 (04 25887		
	Physici /Medio		1. Decedent's Name (First, Middle, Las Roy Carls	on				2. Date of Dea Month July	Day 28, 2	3. Time of Death 2:35 P.		
	Examir	er	4a. Fecility Name (If not institution, give				or Location of Death		4c. County			
			8000 Captains Cou 5. Social Security Number 6. So		(In yrs. last birthday)	Freder		9 Date of Birth		erick		
	Funeral Director			M 2□F	49 Yrs.	Months Days		8. Date of Birth (Month, Day July 29	9, 1954W	9. Birthplace (State or Foreig Country) ashington, D. C		
	Maryland e-f show	ctor	10a. State 10b. County Maryland Frederi		10c. City, Town or Lo Frederick	cation				10d. Inside City Limits 1 ☐ Yes 2 反 No		
	h with the	Funeral Director	10e. Street and Number 8000 Captains Co	urt		10f. Zip Code 2170	1		10g. Citizen of W			
036	72-0030 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show olicel Exercities must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify	e - American Indian, k, White, etc. : white		
215-0	. na	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of work id)	ing	16b. Kind of Bu	siness/Industry		
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and	d a b s	To Be C	17. Father's Name (First, Middle, Last) Roy E. Carls				18. Mother's Nam	e (First, Middle, Rennebe)		θ)		
Maryland 21215-0036	and and send	Ť	19a. Informant's Name/Relationship (t and Number or Run Court, F	al Route Numbe	r, City or Town,			
Baltimore,	00-		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □			matory or other pla	(ce)	Date 2/2004		City or Town, State		
Saltin	permit. Pag Department Importent: I eny injury o		*4 □Donation 5 □Other (Specification 21. Signature of Funeral Service Licen	<u> </u>	0	2. Name and Addre	ess of Facility S	tauffer	Funeral	. Home		
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68760,	cate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):		<i>I</i> =/			,		
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	uires that n signed b	by	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	nderlying cause gi	ven in Part I.			nbute to the cause of death? 3 Probably 4 Unknow		
Records,	The law requi	Completed						24a. Was autop	isy p	Vere autopsy findings availab irror to completion of cause of leath?		
a	iclen: Th certificate ector, pag	e Co	25. Was case referred to medical						/	☐ Yes 2☐ No		
Viita		o Be	examiner?	Hospital:	2 TER/Outcotts	0:	26. Place of Deat					
ō	ling After fune	H	27. Manner of Leath	28a. Date of Injury (Month, Day	28b. Time o	f 28c. Inju Wo	her: 4 Nursing Ho		now injury occurr			
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, st (Specify)			28f. Location (S City or Tow		er or Rural Route Number,		
	ns Hospit n 24 hour ne Funera	Medical (29a. Certifier 1 Certifying Ph (Check only 2 Medicel Examone)	ysician: To the best of niner: On the basis of and manner state	examination and/or in	h occurred at the to exestigation, in my	ime, date and place, opinion, death occur	and due to the o	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)		
•	To the within To the comp	W	29b. Signature and title of certifier	M :	W />		o 06181		29d. Date signed	(Month, Dey, Year)		
F	5		30. Name and address of person who	11		Print)			no no			
	St	ate	Johns Hopkins 31. Date filed (Month, Day, Year)	32. Registra	's Signature	wolte	St Ba	Himor	E INT	0 21287		

			For State Registrar	State of Mar		artment of F rtificate of			iene	Marina Ma	2588	3.9	
	Physici		1. Decedent's Name (First, Middle, Last)	Martin	Cruz			2. Date of Deat Month July 2	h Day	Year	3. Time of De 1632	ath M	
	/Medic Examin		4a. Facility Name (If not institution, give st Suburban Hospital	reet and number)			r Location of Death hesda	-	4c. County o				
	Funeral Director		NONC	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 30,	^{Year)} 1925	Count	ace (State or Fo ry) duras	o <i>reig</i> n	
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom		Oc. City, Town or Lo		wood		10d. Inside City Limit				
	th with the 23a or 28e	ai Director	10e. Street and Number 7211 Millcrest T	errace		10f. Zip Code 208	355	1	ry?				
9800	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or items 23a or 28e-f show odont. The Modical Exartifat rinal te molified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Evi Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cub 1⊠ Yes 2□ No	dispanic Origin? (Si an, Mexican, Puerto Specify: HO						
21215-0036	within 72 h ene. then netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use retire	during most of won d)						
ਰ	2 should be filed v and Mental Hygie Is marked other t aumatic event, In	To Be Co	17. Father's Name (First, Middle, Last) Patricio Cruz		Cons	struction	ruction Worker 18. Mother's Name (First, Middle, Carlota Du						
	nd 2 lith a 27 L		19a. Informant's Name/Relationship (Typ Ritza Martinez (Da		7211	Millcres	and Number or Ru t Terrace				>ode)		
Baltimore,	Pages ment of ent: If it		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑Re '4 □ Donation 5 □ Other (Specify)		Valle de	angeles	Cem 8/30)/2004	20c. Location - C	F	Hondura	s	
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rds, P	es be	by P	Part II. Other significant conditions conf	ributing to death but (not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contrib		cause of death		
Record	The law ate has b page 2 si	Completed						24a. Was ar autopsy perform 1 Yes 2	pri 1ed? de	or to comp ath?	sy findings avai pletion of cause	lable e of	
Vital	Physicien: T this certificat ral director, pi	o Be (25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	ospital:	2 ER/Outpatien	t 3 DOA Oth	0.5	th (Check only one		(Canaife)			
ion of	ding After fune	ation: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injur Wor	y at	28d. Describe ho					
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	To the Hospitel within 24 hours a To the Funeral Completely filled	ledicai	(Check only one) 2 Medical Examin	cian: To the best of a er: On the basis of ex and manner state	camination and/or inv	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manr ite and place, an	ner as stat d due to ti	ed. ne cause(s)		
•	A P	Σ	29b. Signature and titlb of perific	D M	0	29c. Licens		1 .	od. Date signed (1	t	
	Sta	ite	30. Name and address of person who con Set CR 6. Push Shadan 31. Date filed (Month, Day, Year)	npleted cause of dea 45 //5 32. Registrar's	10 old	Georges	bwn Ra	nd, Rock	eville ,	ud	20852	2	

Registrar

CRUZ, MARTIN 7/28/04 1632

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Reginald July 26, 2004 14:41 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4409 Beckenham Place Upper Marlboro Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 214-08-5946 Yrs. Director 35 13, 1968 Washington DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Mudical Examiner must be notified at Director Maryland Prince Georges Upper Marlboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "naturel", or items 23a 4409 Beckenham Place 20772 filed within 72 hours after deeth Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: þ Specify: **Black** 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Communications Specialist Private other permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: if Item 27 is markad oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie King Laura Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Boyd / Mother 9904 Caltor Ln. Ft. Washington, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Aug.2, 2004 Clinton, Md. ^ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lifensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Mariboro Pike Forestville Md. 20747 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Dissecting /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Lines of injury Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed -transit and Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown δ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2 No To the Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onli one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 XYes 2 □ No P 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a etely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 27, 2004 30. Name and address person who completed cause of death (Item 23a) (Type, Pnnt) 111 Penn Street, Baltimore, Maryland 21201 Pamela E. Southan MI

31. Date filed (Month, Day, Year) State JUL 3 0 2004 Registrar



				State of Maryland				•	•	
			For State Registrar			rtificate of			100 AU	25000
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici		Lura Mae Cooper					July 29	Day Year 2004	1:31 p M
,	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Deal	
	- Admin		Washington Advent	ist Hospital		Takoma	Park		Montgome	erv
-	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
	Director		578-42-3966 ^{1□}	M 2∰F 85	Yrs.	Months Days	Hours Min.	(Month, Day, Y May 27,	1919 Vi	rginia
	p .		Usual Residence of Decedent							
	thow		10a. State 10b. County		Town or Lo	ocation				10d. Inside City Limits
:	Ba-fs	cto	Maryland Montgome	y Sil	lver S	Spring				1∭Yes 2☐No
	within 72 hours atter death with the Maryland ene. Than "natural", or tlems 23a or 28a-f show Te M. vical Examiner and be natified at	Funeral Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
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	r deg	Tue		Was Decedent Ever in U.S. Armed Forces?	. 13.	Was Decedent of H If Yes, specify Cub.	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
9	or I	by F	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		1□Yes 2⊠No	Specify:		Specify:	White
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7	with:	ᇤ	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		ω,		2	
N	filed Hygi ther int.		17. Father's Name (First, Middle, Last)		nomen	laker	18. Mother's Nan	ne (First, Middle, Ma	Own Home	
ă	d be	Be C	Moses Speakes				Irene		,	
<u>_</u>	mark mark	ပ္	19a. Informant's Name/Relationship (Ty	roe. Print)	19b. Maili	ng Address (Street			City or Town, State.	Zin Code)
E E	id 2 sith ar		Linda Harris - Dau							
คั	Hea Hea tem		20a. Method of Disposition	20b. Pla	ice of Dispo	osition (Name of matory or other pla	Lane, nya		Maryland	
2	ages ant of t: If i		1 X Burial 2 ☐ Cremation 3 ☐ F 1 4 ☐ Donation 5 ☐ Other (Specify)	Tellioval IIOIII State			^{сө)} tery 8/2	/2004 P	monture d	Managar 1
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Broatcatt: If them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, it a Maryleal Examination at the maillied at once.		21. Signature of Fuperal Service Licens						rentwood, neral Home	Maryland D A
a T	Depa Depa Impo any ir		1 66 HATT	Tan					ttsville,	
	-		23a! Parti. Enter the disease, or compl	ica on that caused the death.						Approximate
			shock, or heart failure. List only or immediate Cause (Final	r cause on each line.			•			Interval Between Onset and Death
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	uted ansit	Examiner	Cause (Disease or injury that initiated events	Alrial	di	lowill	atro	2		
,	n and ial-tra	Exa	resulting in death) Last	Due to (or as a conseque	ence of):					
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9	ifficat g ph) as th	ed				M-				
Вох	n cert andin use	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan		75			23d. Date of de	livery
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>		To B	examiner?	Hospital: 1 ☐Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Ott	ner: 4 🗆 Nursing H	lome 5 Residen	ice 6 Other (Spe	ecify)
			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju- Wo		28d. Describe how		
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	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th	edical	(Check only 2 Medical Exami	sician: To the best of my know iner: On the basis of examination	rledge, deat on and/or in	th occurred at the ti	me, date and place opinion, death occu	, and due to the cau	ise(s) and manner as	s stated. e to the cause(s)
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens				
	5 × 6 2		250. Signature and title of certifier	MING	-		5403	290	d. Date signed (Mont	un, Day, 1981) ! . !
. /						_	-	/	121102	7 .
N	\mathcal{O}_l		30. Name and address of person who c	ompleted cause of death (Item:	23a) (Type	Print)	OLL AV	E# 26	O, TAKO	MAPARK
			31. Date filed (Month, Day, Year)	32. Registrar's Signatu	/ 0	OLAL	-w / / /	MD T	0911	
	Sta Regist		31. Date filed (Month, Day, 19al)	Se. Programar & Signato	boots					

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last	State of Maryland / [Certificate of	Death	Reg. N	0001	2589
hysici	an	JANET L. CHANDOI					ay Year 3 2004	HIDEA
/Medic xamin		4a. Facility Name (If not institution, give		4b. City, Town, o	r Location of Death		c. County of Death	1
		Memorial H	tosputal	East	on	-	Talbo	+
neral ector	6	5. Social Security Number 6. Se 017-05-0391 Usual Residence of Decedent	- W	thday) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Yea MAR 28 19	9. Birth Co. 09 MA	nplace (State or Forei untry) SS
T at		10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limi
realiffe	Funeral Director	MD CARO	LINE DE	INTON 10f. Zip Code		10g. C	itizen of What Co	1 X Yes 2 □ Nuntry?
11 Per	Ö	410 COLONIAL DR	IVE	2	1629		USA	
No. of Contract of	uner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub.	lispanic Origin? (Specit an, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Amer Bfack, White	
o oner then natural, or tema 2.5s or 2.5s - 1 stowers, the Medical Examinat must be multiple at	by	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:	1 □ Yes 2 🛣 No	Specify:		Specify: W	HITE
Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation 16a. de completed) Colfege (1-4or 5+)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	16b.	Kind of Business/I	Industry
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even	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (i		,	
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traur		JOHN ROBERT CHAN		. Mailing Address (Street	OROUGH ST.			
other		20a. Method of Disposition	20b. Place o	f Disposition (Name of	Dat		Location - City or	
y or c		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	ry, crematory or other pla RY S CHURCH		8-4-04 P	ISCATAWA	v m
Important: if item 27 is marked eny injury or other traumatic ev once.		21. Signature of Funeral Service Licens	-	22. Name and Addre	ess of Facility ELFENBEIN	S NEWNAM	FUNERAL	
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irector, page 2 should I	Completed					24a. Was an autopsy performed?	prior to death?	topsy findings availa
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2 0	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ER/O	utpatient 3 DOA Ct	ner: 4 Nursing Home		6 □Other (Spec	cify)
funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of 28c. Inju Injury Wo	ry at 28	d. Describe how in		
. 2	catic	2 Accident investigation 3 Suicide 6 Could not be		M 1	Yes 2 □ No			
å	Certification:	4 Homicide determined	28e. Place of fnjury - At home, fa building, etc. (Specify)	arm, street, factory, office	28	f. Location (Street and City or Town, Sta	and Number or Ru te)	ral Route Number,
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runeran tely filled	edic			29c. Licen	se number	29d. D	ate signed (Month	n, Dey, Year)
to the Funeral Director; y completely filled in by the f	Medical	29b. Signature and title of certifier	5/12	3-				
Funeral	Medic	29b. Signature and title of certifier	2 Contra MO	D31	1466		1/23/0	4
Funeral	Medic	30. Name and address of person who		(Type, Print)	700	7	1/23/0	4
completely filled	Medicate	30. Name and address of person who	completed cause of death (Item 23a) EDER III M.D. 50. 32. Registrar's Signature	(Type, Print) 3 IDLEIWLD A	700	, MD 2160	1	<i>Y</i>

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	ysician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
		4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of
0		Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limit
ith the Ma or 28a-f	A notified	MD FREDERICK UNION BRIDGE 1 □ Yes 2 🖺 N 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal hygiene. Important: If Item 27 is marked other than "natural", or thems 23a or 28a-7 show	Examiner must be notified by Funeral Director	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 3 No Hyes, Give 1 Sec. In Observation 1 Sec. In Observation 1 Sec. In Observation 2 No Specify: Specify: WHITE
d 21215-0020 filed within 72 hours af Hygiene. ther than "natural", or	nt, the Medical E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) PATIENT CARE 16b. Kind of Business/Industry 16b. Kind of Business/Industry NURSING HOME
Maryland 212. d 2 should be filed within thand Mantal Hygiene. 7 is marked other than	atic event To Be (17. Father's Neme (First, Middle, Last) EARL HADDAWAY 18. Mother's Name (First, Middle, Maiden Surname) SARAH VIRGINIA JEFFERSON
Mar and 2 sho saith and in 27 is mar	traum	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 461 HIGHLAND WAY HAGERSTOWN, MD 21740
Baltimore, semit. Pages 1 ar Department of Head mportant: if Item 2	ary or other	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Location - City or Town, State
Balti permit. Departm	any inje	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601
Physic /Medi Examii	ical ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Bue to (or as a consequence of):
		Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest b. Due to (or es e consequence of): C. Due to (or as e consequence of): d.
. 0 03	ached hysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Vanknow
ecords, aw requires the is been signed sebould be signed	z should be d pleted by	24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth?
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DIVISION al or Attending s after death. I Director: After	ed in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
DIVISION To the Hospital or Attency Within 24 hours after death To the Funeral Director:	entereny medical C	29a. Certifier (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the vithin 2	W	29b. Signature and title of certifier 29d. Date signed (Month, Day Year) 29d. Date signed (Month, Day Year) 27 04
		30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 1 d ANNA nolks Rd. Ensott City Melvin Fordon MD 950101d ANNA nolks Rd. WD 2004
Reg	State gistrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** Walter L. Conway July 30 2004 6:30 A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Iorien Nursing & Rehabilitation Columbia Howard 8. Date of Birth (Month, Day, Year) Oct 16, 1913 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 **3**M 2 ☐ F 90 Maryland Director 214<u>38 6328</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 6500 Freetown Road #111 238 21044 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. or items Black, White, etc. 2 should be fited within 72 hours after and Mental Hygiene. is marked other than "naturel", or ite 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mailman Postal Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter M. Conway Katherine McLaughlin Pages 1 and 2 should nent of Health and Men other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If itsm 27 is
stry injury or other trau Jennifer Sclafani/Personal Repr. 6311 Ferryboat Circle Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cem. 8-2-2004 Baltimore, MD 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. OM01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Heart b months Pnysician Cong estive /Medical Due to (or a consequence of): **Examiner** oro hasy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760. Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by of Vital Records, 1) emention 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: mellitus 1 ☐ Yes 2 ☐ No 2 🔯 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Injury 1 Natural 5 Pending s after do-ral Diractor: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hin 24 hours a tha Funaral I filled 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier m.D D56531 Hickory Ridge Road, Columbia, MD21044 cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 10780 mD. 31. Date filed (Month, Day, Year) 32.1 State 2004 Registrar

Damien Emanuel Coleman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 04895State of Maryland / Department of Health and Mental Hygiene MAN For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 28 2004 2004 2004 0044 AM Damion Emmanuel Coleman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Prince George's 4b. City, Town, or Location of Death **Examiner** 6372 Maxwell Drive Camp Springs 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**⊊**M 2□ F Yrs. Director 577-02-0505 Washington DO 25 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Evanioer must be notified at Prince George's Upper Marlboro 1 Yes 2 No MD Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 U.S.A. 20772 12000 North Marlton Ave Items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced neturel Completed other treumatic event, the Mudical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Short Order Cook Resturant 12th and Mental Hygin Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lorrell Smith Coleman, Sr. Anthony Earl 19a. Informant's Name/Relationship (Type, Print) 20772 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 No. Marlton Ave, Upper Marlboro Md item 27 Lorrell Doughty 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 08-04-04 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Clinton Resurrection Cemetery Md 4 □ Defration 5 □ Other (Specify) 21. Signal re Funeral Service Lic 22. Name and Address of Facility D.L. McLaughlin's Funeral Service, Inc. 1425 Maryland Ave, NE

Mashington, DC 20002

Approximate

Internal Repulsion 23a. Part1. Enter the disease, or domplications that caused the death. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of): iding physician Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death Month Dav 5 Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Yes 1 Yes 2 No 2 No Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: $_{4}\Box$ Nursing Home 5 \Box Residence 6 xOther (Specify) At SCENE 1 X Yes 2 □ No Certification: To 1 Inpatient 2 EN/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending receased sho death. investigation 7-28-04 12:12 A M 1 ☐ Yes 2 🔀 No 2 Accident after death Director: the 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number or Rur 3 Suicide þ 4 Homicide within 24 hours 29a. Certifier Medical 2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

K 31. Date filed 0 2 2004 AUG

30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

itle of

29b. Signature and

2. Registrar's Signature

Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

July 28, 2004

		1 = For State Registrar	State of Ma	•	partment ertificate			nd Menta	ll Hygier	2001.	25895	
Physic /Medi		1. Decedent's Name (First, Middle, Las Richard	Harrison	Crider,	Sr.			Mo		Day Yea		
Exami		4a. Facility Name (If not institution, give Washington Count	y Hospital		Hage	own, or Lo	v n		V	lc. County of De Vashing	on	
Funeral Director		5. Social Security Number 6. Security Number 227-60-5042 Usual Residence of Decedent	ex 7. Age	(In yrs. last birthd	Months		Hours I	Min. (Mo	ne of Birth Sonth, Day, Yea y 1, 19	(r)	inthplace (State or Foreign Country) .rginia	
e Maryland le-f ehow	ctor	10a. State 10b. County Maryland Washing		10c. City, Town o Hagers							10d. Inside City Limits 1x□XYes 2 □ No	
th with the 23a or 28	Funeral Director	10e. Street and Number 535 Frederick Str	eet		Code 21	L740	10g. (10g. Citizen of What Country? U.S.A.				
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rland in indicate in its section in	O	Edward Lamb								en Sumame) Rhineha	art	
Mary and 2 shore that and h		19a. Informant's Name/Relationship (Type, Print) Joan E. Crider - wife 535 Frederick Street, Hagerstown, I									Zip Code) Land 21740	
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Balt permit. Depertr importe any inji		21. Signature of Funeral Service Licen	soo Tot		22. Name and 415 Eas					neral Ho town, M	ome Maryland 21740	
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S 20 9	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in th	ne underlying ca	use given i	in Part I.	23	e. Did tobacci		to the cause of death? Probably 4 Unknown	
II Records, P.O.: The law requires that the cate has been signed by the page 2 should be detached.	Completed							_	a. Was an autopsy performed?	prior t	autopsy findings available of completion of cause of ?	
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To t To t	Z	29b. Signature and title of certifier	Luchan		(License ni	603		C	Date signed (Mo	104	
3H-1		30. Name and address of person who are filed (Month ATGY 47) 2.2	completed cause of de	ath (Item 23a) (Ty - 5 H E T	Print)	Оро	al Co	ort	Hager	stown	Maryland	
Si Regis	ate trar	31. Date filed (Month AUG* 6) 2 2	2004 32. Higher	s Signature	Speke							

			For State Registrar	State of	Maryland		artment of H		nd Mental	, ,	ene . N2 0 0	1	25896	
			1. Decedent's Name (First, Middle						2. Date of	of Death		rear	3. Time of Death	
	Physici /Medic		Sadie Ruth CLA	RK							2004	rear	6:00 a. M	
	Examin		4a. Facility Name (If not institution	-	ber)		4b. City, Town, o				4c. County of			
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B	Funeral Director		5. Social Security Number 220–16–3777	6. Sex 1 ☐ M 2 ☒ F	. Age (In yrs. Ia		Months Days			h, Day, Y	1914		place (State or Foreign htry) ryland	
	pu 🖈		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Lo	antion						0d. Inside City Limits	
	sho	5	,	ington	Too. Oity,	, 10411 01 20	Hager	o t our					1 X Yes 2 No	
	28e-1	Director	10e. Street and Number	Ington			10f. Zip Code	SCOWII		100	. Citizen of Wh	at Cour		
	3a or		1079 Wayne Av	enue				:	21740	.09	US		,.	
	death ms 2	Funeral	11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. \	Was Decedent of H	lispanic Origin	n? (Specify Yes	or No-	14. Race -	Americ		
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21215-0036	hour tural	ed t	15. Decedent			16a. Deced	dent's Usual Occup	ation		16	b. Kind of Busin	ness/in/	dustry	
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la	2 should be to and Mental I is marked of reumatic eve	2	Samuel Claton	Leiter, Sr	•			Edı	na Pearl	Mar	tin			
Maryland	2 shc and Is m		19a. Informant's Name/Relationsh				ng Address (Street							
	1 and 2 Health Iem 27		Brian Leiter	- nephew	20h Bir		Box 27		Ling Wat					
Jor	in of h		20a. Method of Disposition 1 № Burial 2 ☐ Cremation		ומוט		sition (Name of natory or other pla			11	c. Location - Ci			
altimore,	it. Pa irtmer irtent njury		' 4 □ Donation 5 □ Other (Sp. 21. Signature of Sungral Service I		Ced		wn Mem. I		7/31/04				Maryland	
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	Pnysician		shock, or heart failure. List	only one case of ear	netro.	10710	fyste	uic l	Andi	MA	onla	1	Interval Between Onset and Death	
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	death e atte	Physician/M	in the past 12 months?	4□Pregna	th 2 Fetal on that time of dea]Ectopic pregnancy] Other <i>(specify)</i> _	<i>'</i>			Month		Day Year	
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	es gu	by F	Part II. Other significant condition	ns contributing to dea	ith but not resul	lting in the u	nderlying cause giv	en in Part I.	23e.	Did tobac		_	e cause of death?	
ord	w requires been sign should be	ted							_	1 🗌 Yes	2 No 3	Proba	ably 4 Unknown	
Records,	aw as b	ompleted								Was an autopsy	orio	r to con	osy findings available inpletion of cause of	
H	Th ate pag	Co					_		1 🗆 Y	oerformed es 2. €	d? dea		2 No	
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Lou	00	f Death (Check o					
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	ding F h, After funer	tion	1 atural 5 Pending	(Month	Day Year)	Injury	Wor	k? Yes 2 □ No		IDO HOW	injury occurred			
Division	or Attending after death, Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Place of			eet, factory, office		28f. Locati			or Rural	l Route Number,	
á	s after s after al Dire	Certification:	4 Homicide	building	g, etc. (Specify)				City o	r Town, S	State)			
	To the Hospitel or At within 24 hours after or To the Funerel Directompletely filled in by	ledical	29a. Certifier (Check only one) Check only 2 Medical I	Physicien: To the be Examiner: On the bas and manne	sis of examination	rledge, death on and/or inv	occurred at the tir restigation, in my o	ne, date and p pinion, death	place, and due to occurred at the ti	the caus me, date	e(s) and manne and place, and	er as sta I due to	ated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	01			29c. Licens	e number		29d.	Date signed (A	Month. [Day, Year)	
•			Struck	how, M	0		1)36	655		50	14 29	12	004	
,H	4-2		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	, A	Age It	ww	MI	12	1740	
	Sta Registi		31. Date filed (Month ADay (° 0)	2 2004 32. Rg	gistrar's Signatu	ire	heres	100	1	/				
	riegisti	चा				-	Mary Mary							

SADIE RUTH LEITER CLARK

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** Year Emma L. Chaney July 25 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2X F 82 214-14-5880 Vrs Director Sept. 2, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or items 23a or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Arnold 1 Yes 2 No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1032 Shore Acres Road 21012 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 212 No White Specify: þ 3 X Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Federal Employee Secretary permit. Peges 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If item 27 is marked other th. any injury or other traumatic event, the once. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Small Emma Velten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte L. Crouse/Daughter 1032 Shore Acres Road, Arnold, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) July 26, Metro Crematory Baltimore, MD 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronary /Medical Due to (or as a consequence of): Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕻 No After this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO16964 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ritchie He H ACONAS James 31. Date filed (Month, Day, Year) Registrar's Signature State 2004 Registrar

	Į,	A FOI	ndelible ink. Ensure A partment of Health and N ertificate of Death	Mental Hygie	•	25292
Physicia /Medio		1. Decedent's Name (First, Middle, Last) Amy Louise Conklin		2. Date of Death Month	3 2004	3. Time of Death 3:50 P. M.
Examin		4a. Facility Name (If not institution, give street and number) North Arundel Hospital	4b. City, Town, or Location of Death Glen Burni		4c. County of Death Anne Ar	undel
Funeral Director		5. Social Security Number 475-20-4403 6. Sex 1 M 2 F 7. Age (In yrs. last birthday 2 F 82 Yrs) Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan. 10,	^(ear) 922 9. Birth	pplace (State or Foreign intry) MN
th with the Maryland 23s or 28s-f show ust be notified at	tor	10a. State 10b. County 10c. City, Town or MD Anne Arundel	Location Severna Par	rk		10d. fnside City Limits 1 ☐ Yes 2 ☒ No
with the	i Dire	10e. Street and Number 442 Lynwood Drive	10f. Zip Code 21146	100	g. Citizen of What Cou USA	intry?
UK LI M 1215-0036 within 72 hours after death with the Maryland ane. Then "natural" or items 23s or 28s-f show the Madical Examiner must be notilised at	by Funeral Director	-	3. Was Decedent of Hispanic Origin? (Spirit Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- Display Rican, etc.)	14. Race - Amer Black, White Specify:	
C N na-	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. De (G (iffe) (Iffe	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired) Homemaker	king	Bb. Kind of Business/Ir Home	ndustry
	To Be C	17. Father's Name (First, Middle, Last) William Beebe	Unava	ailable	·	
Z Sping Z		Diana C. Baker/Daughter 44	ailing Address (Street and Number or Rur 2 Lynwood Drive, Se			p Code) 146
0 0 0 5		4 Donation 5 Dotter (Specify)	rematory of other place) nt Demetery July	7 28 I 2004	oc. Location - City or T Davidsonvi	lle, MD
Baltime Permit. Pag Department: Important: any injury C		21. Signature of Funeral Service Licensee	Barranco & Sons, P. 495 Gov. Ritchie Hw	A. Severr y, Severr	na Park Fur na Park, MI	neral Home 21146
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Endocumd resulting in death)	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	À			
8760, ate be executed hysician and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	embdi			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medic		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
rds, P.	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	the cause of death?
Division of Vital Records, I or Attending Physician: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed			24a. Was an autopsy performe	24b. Were auto prior to co death? No 1 \(\sum Yes	opsy findings available impletion of cause of
Ysician:	To Be	25. Was case referred to medical examiner? 1 Yes	Others	th (Check only one)	ce 6 ☐Other (Specia	fv)
Sion of ending Pheath. or: After thin the funeral	Certification: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	28d. Describe how		,,
Divis	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, :	<i>,</i>	
he Hospi n 24 hou he Funer pletely fill	edicai	29a. Certifier Ceneck only ane) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the best of my knowledge, de (Check one) Certifying Physician: To the C	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as s and place, and due to	stated. o the cause(s)
To at To at comp	Σ	29b. Signature and title of certifier Arthur	29c. License number D 4-3977	296	Date signed (Month,	200H
•	ì	30. Name and address of person who completed cause of death (Item 22a) (Type 20)	e, Print)	m/> 2	ioh	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registra's Signature 2 9 2004	bode .			

Amend item # 7,8,per FH,G835,9/2/04
State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15^{Day} Month 04 **Physician** Mae Bell Cave 9:50 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Southern Maryland Hospital Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 / 8 / 1 930 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Birthplace (State or Foreign
Country) 1□M 2XF 579-22-0699 Director No . Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other then "natural", or itams 23a or 28a-f shov traumatic event, the Madical Exametration by multiled at 1 Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020 1525 28th Street Apt. #302 S.E. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: black If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: If item 27 Is marked other then ' Elementary/Secondary (0-12) 12th College (1-4or 5+) Federal Govt. Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Odom ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 19a. Informant's Name/Relationship (Type, Print) item 27 I George Cave/husband 1525 28th Street S.E. #302 Washington DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glenwood Cemetery 7/28/04 Washington DC 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service bicensee 22. Name and Address of Facility
B K Henry Funeral Chapel Inc. Henry 18 Washington DC 20002 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final SEDSIS Physician disease or condition resulting in death) /Medical Due to (or as a con equence of) Renal disease **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last myoccobal infarction and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 neumonia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ erebro Vascular 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page certificate 212 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 patient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pendina death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel [Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 501CONICWO D0095314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0100 KWO, 6192 Oxon Hrw RD, 576 507, 0xon Hru, mg SYLVESTER 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 0 2004 Registrar

	100		1- For Amend Item	State of Ma 24a per V	ryland / Der erb., G834	artmen 08/18 Prificati		ealth and hb Jeath	Mental Hy	/giene Reg. No 2 ()	04 2	5900
ı	Physic		Decedent's Name (First, Middle, Last) Patsy L	ouise	Cosne	r			2. Date of D Aug 3		Year	of Death O am
Sec.	/Medi Examir		4a. Fecility Name (If not institution, give s 20201 Dickerson h		ad		Town, or	Location of Dea		4c. County	of Deeth	io aiii
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda)		1 Year	If Under 24 Hrs	8. Date of Bi	Alleg		State or Foreign
	Director		219-34-7206	M 2 X	65 Yrs.	Months	Days	Hours Min	Oct 1	3, 1938	WW	
	e Maryland	ctor	10a. State Allegar	ıy	10c. City, Town or L Flin	tstone						side City Limits Yes 2 No
	th with th	al Director	10e. Street and Number 12310 Cee Cee La	ine		10f. Zip		21530		10g. Citizen of W	/hat Country?	
9036	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "natural", or Items 23e or 28e-f show event, the Medical Exeminar must be notified at	d by Funeral	11. Marital Status X 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 □ Yes 2 □ XV If Yes, Give Year or Dates:		Was Deced If Yes, spec	X	spanic Origin? (Spanic Arguments) Specify:	Specify Yes or Note Rican, etc.)	14. Race Black Specify:	- American Inc k, White, etc. White	ian,
21215-0036	filed within 72 h Hygiene. kther than "natu ent, ire Modical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Giv	edent's Usua e kind of wor DO NOT us 'ess	l Occupa k done di e retired)	tion uring most of wo	orking	Holiday		
Maryland	should be filed nd Mental Hygid marked other umatic event, II	To Be	17. Father's Name (First, Middle, Last) Jesse McCoy							, Maiden Sumame St) McCo		
	nd 2 sh lih and 27 is m r traum		19a Gaynor Cosner (Type	e, Print) husb	and 196. Mail	310 Ce	(Street a	nd Number or R Be Lane	urai Routa Numb Flint	er, City or Town, S Stone	State, Zip Code MD	21530
Baltimore,	0 = =		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Disp Scarpelli F			, P.A.	Date 8/4/2004	20c. Location - C		ate MD
Balti	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	Capal	11 - 2	2. Name 9 5	enpell 8 Viro	Furieral iinia Aven	Home, P.A	erland, MD	21502	
	Physician /Medical Examiner	ler	23a. Papl 1. Enter the disease, or complic shock, or hear failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying	Gliob Due to (or as a	lastoma M consequence of):			, such as cardia	c or respiratory a	rrest,	Interv Onse	eximate at Between t and Death
k 68760,	ertificate be executed ing physicien and e as the burial-transit	Medical Examiner	Cause (Disease or Injury that initiated events resulting in death) Last		consequence of):							
.O. Box	at the death certific by the attending p tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetel death 3	□Ectopic pre				23d. Date Mon	of delivery th Day	Year
T SE	The law equires thet the the has been signed by the page 2 should be detached.	by	Part II. Other significant conditions conf	ributing to death but	not resulting in the t	inderlying ca	use giver	n in Part I.	m .	obacco use contril	oute to the caus	
Vital Records, P.	10 11	e Completed	25. Was case referred to medical					OS Place of De	24a. Was autoperfor 1 Yes	osy rmed? de 21 No 1	ere autopsy find ior to completion ath? Yes 2 No	n of cause of
of Vi	Physician: this certific ral dire tor,	To Be	examiner?	spital:	2 ER/Outpatie	nt 3 DO	Other	~	dome 5 ☐ Resid		dau (Specify res	ghter's
ion	nding ith. :: After e fune	atlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	of 28	lc. Injury a Work?	at ? es 2∐No	28d. Describe	now injury occurre	d	
Division	Dir	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm, st (Specify)	reet, factory,	office		28f. Location (: City or Tox	Street and Number vn, State)	or Rural Route	Number,
	Mospitel 24 hours a Funeral etely filled	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cien: To the best of er: On the basis of e and manner state	xamination and/or in	h occurred a vestigation,	t the time in my opi	e, date and place nion, death occu	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the ca	use(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	0 -	457 Centa		License			29d. Date signed	(Month, Day, Ye	oar)
	5		30. Name and address of person who do Jose Loveria M.D.	nateted cause of dea	th (Item 23a) (Type,	Print) Seton 1	Drive	Cumbe	rland MF	21502	.,,	
	Sta Registr	4	31. Date filed (Month, Day, Year) AUG 1 8 2004	32. Registrar		bocks	/		. ALIG WIL	2 1002		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 500 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12,2004 **Physician** Month Cynthia July 9:52am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Yrs **Director** 578-72-9051 August 1,1951 Washington DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show traumatic svant, the Medical Examiner must be notified at Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23a 601 L St. S.E. 20003 Completed by Funeral United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. snt: If item 271s marked other than "naturel", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married 1 XYes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oscar Dancy, Jr Irene Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Adams /Cousin 181 Gold Kettle Dr., Gaithersburg, MD 20878 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem Cem 7-23-04 Suitland, MD 22. Name and Adress of Family S. Pope Funeral Home 21. Signature of Funeral Service C 2617 Penn.Ave S.E. Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Um Know v /Medical Due to (or as a consequence myTRuit weiters **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury that initiated events Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe 20 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes i __mpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner Death 28d. Describe how injury occurred After 1. Stural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident the within 24 hours after deatl To the Funaral Diractor: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 rifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) the 29c. License number title of gertifier 29b. Signature and 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Orsun Ave 31. Date filed (Month, Day, Year) State 2 7 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Unpend it the State #23a, PII, 27, 28a-f, perME, G836 & 1234040/15 eath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 7 2004 2004 5:57 PM Kevin Lee Duff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1203 POTOMAC AVE HAGERSTOWN WASHINGTON CO If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**√**2 M 2□ F 219/72/8532 Director Yrs. 1968 Pennsylvania 36 May Usuat Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b. County 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Modical Expendence must be restilled at 10d. Inside City Limits TY Yes 2 □ No Directo MDWashington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1203 Potomac Ave. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No ð Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tech 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Computer Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental ? Is marked of John McNellan Duff Betty A. Cantrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health item 27 I (Wife) 505 Orchard Manor Dr. Boonsboro MD 21713 Karen L. Duff 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 8/10/04 Smithsburg, MD ¹ 4 □ Donation

¹ 5 □ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home 21. Signature of Funeral Service Licensee M01414 425 S. Conococheague St. Williamsport MD 23a. Rant Earter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician Ethanol and Amitriptyline Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each Uncertainty Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physicien Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent oregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 🗆 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Cardiomegaly 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No performed? 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day) Found 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred subject ingested After 1 Natural 5 Pending Found death. investigation 1 ☐ Yes 2X No Accident Prescribtion drug and alcohol Director: 3 Suicide 5 • 47 p ome, farm, freet, factory, office 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 1203 Potomac Ave Found at home 24 hours a Funerel C The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) OCME AUGUST 8, 2004 who completed cause of death (Item 23a) (Type, Print 30. Name and address of person 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month AUG °1 0 2004 Registrar

32. Redistrar's Signature

			1 - For State Registrar	State o	f Maryla			of Health a	and Me		iene	25904
æ.			1. Decedent's Name (First, Middl	e, Last)					2.	Date of Deat	h	3. Time of Death
- *	Physici /Medio		Bessie	Marie		Dixo	n		Ju	Month 1v	Day Year 23. 2004	2:20 P M
	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Tox	wn, or Location o	of Death	,	4c. County of De	ath
	Funeral Director		Millenium Healt 5. Social Security Number	h & Rehab 6. Sex 1□M 2∏F	ilitat 7. Age (In yrs 68	ion Ctr . last birthday) Yrs.	If Under 1 Y	gewater ear If Under a lays Hours	Min.	Date of Birth (Month, Day,		irthplace (State or Foreign Country)
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	e Marylan la-f show	ctor	MD 10a. State 10b. County Prince	e George's		heverly	cation					10d. Inside City Limits 10d. Inside City Limits 10d. Inside City Limits
	ath with th	rai Director	10e. Street and Number 1807 61st Avenu	ıe			10f. Zip Co 2078.	5		1	Og. Citizen of What C United St	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show important: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show all proteinty or other traumatic event. Ite Modical Exertifier roual be rotified at ance.	Completed by Funeral		Marital Status 1 □ Never Married 2 □ Marned 1 □ Never Married 2 □ Marned 3 ▼ Widowed 4 □ Divorced 1 □ Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:								nerican fridian, lite, etc. ack
Maryland 21215-0036	ithio 72 h ne. nen "natu n Medical	npietec	(Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give i	OO NOT use n	lone during most	of working	1	6b. Kind of Busines	,
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yland	should be find Mental Himarked of	To Be	Murray Gerald					Ka	ate Mo	nk		
	and 2 sh ealth and n 27 is rr		19a Informant's Name/Relations Michael Dixon/			7112 H	awthro	ne Stree	et Lan	dover,	City or Town, State, MD 20785	-
altimore,	Pages 1 nent of Hu int: If Iter iry or oth		20a. Method of Disposition ¶¶Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from	Charle	Place of Dispos cemetery, crem Linco	atory or other	r place)	Date 7/ 31/		Oc. Location - City o	
Balti	permit. P Departm Importer any inju		21. Signature of Funeral Services	Liceosee	_			oln Fune			wood, MD 2	20722
35	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a.	ach line.							Approximate Interval Between Onset and Death
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	and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	(or as a conse					•		
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.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oirth 2 Fet nant at time of	al death 3 🗌	Ectopic pregn Other (specif				23d. Date of de Month	elivery Day Year
٥.	uires that signed b ld be deta	þ	Part II. Other eignificant condition	S Mell	eath but not re	sulting in the un	derlying caus	e given in Part I.				o the cause of death?
Division of Vital Records,	ie law requiri has been si ge 2 should I	Completed	Geneal	Delil	4	_				24a. Was an autopsy perform	24b. Were a prior to death?	utopsy findings available comptetion of cause of
ā			OF Management to made							1□ Yes 2	ZNo 1 □ Ye	s 2 No
5	Physician: The I this certificate har ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	Inpatient 2] ER/Outpatient	3□ DOA	Other _		heck only one		
ō	두 등 교	-	27. Manner of Death	28a. Date	of Injury	28b. Time of		Injury at Work?			ice 6 □Other (Spe v injury occurred	эспу)
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	To the Hospitel within 24 hours a To the Funerel C completely filled	Medical (29a. Certifier (Check only one) Certifyin	g Physician: To the Examiner: On the b and man	best of my kn asis of examination of stated.	owledge, death ation and/or inv	occurred at the estigation, in i	ne time, date and my opinion, death	d place, and h occurred a	due to the cau at the time, dat	use(s) and manner a se and place, and du	s stated. e to the cause(s)
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R	(ω)		30. Name and address of person	who completed caus	se of death (Ite	m 23a) (Type, F	Print) AVE S	STE ZF	31 A	NNIAM	ous, mi	D. 21401
*	Sta		31. Date filed (Month, Day, Year)		egistrar's Sign	ature	4,					-

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death 19^{pay} Month July **Physician** 2004 Fiorella DiGiacomo рМ 9:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Arnold Anne Arundel FutureCare Chesapeake If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22,1906 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF 97 220-14-1032 Director Chieti. Italy Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Severna Park MD Anne Arundel 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21146 811 Teakwood Drive "natural", or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No λq 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygiens important: If item 27 is marked other that any injury or other treumatic event, Item 2006. Homemaker **Home** 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles D'Angela Anna "Unavailable" 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Soverna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Mary J. Smith/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State July 23 Baltimore Nat. Cemetery Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signiture of 22. Name and Address of Facility Barranco & Sons, uneral Service Licacie P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cona welle /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No
9 Unknown Year Month 4 Pregnant at time of death 5 ☐ Other (specify) P.O. be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 Yes 2 No To the Hospital or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 1 🗌 Yes 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident Injun 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier evanstighway #20y Millersville death (Item 23a) (Type, Print State

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Registrar

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Physicia /Medic Examin	al	Warren Thomas 4a. Facility Name (If not institution, give	Daywalt		4b. City, Town, o	r Location of Death		,	004 1:00 p M
Funeral Director		212-60-2103		(In yrs. last birthda 52 Yrs.		asadena If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 1	Year)	ne Arundel B. Birthplace (State or Foreign Country) MD
f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel	10c. City, Town or		adena			10d. Inside City Limits
ms 23a or 28e-f show	Funeral Director	10e. Street and Number 215 Catalfa Da	vwalt		10f. Zip Code	1122	10	g. Citizen of Wh	nat Country?
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and Mental Hygi marked other umatic event,	To Be (17. Father's Name (First, Middle, Last Warren F. Daywal 19a. Informant's Name/Relationship (t	19h Ma	ailing Address (Street	Amy Fo			·
if Health and Meritem 27 is marked other traumatic		Kathleen Daywalt		20b. Place of Dis	15 Catalfa sposition (Name of rematory or other place	a Avenue,	Pasadena Date 2	, MD 2	21122 City or Town, State
Department of Important: If it any injury or o once.		1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special Structures) 21. Sign the Fune at Service Lice	(y)		Crematory 22. Name and Addre	ess of Facility	2001	Baltimo	re, MD k Funeral Ho k, MD 21146
Medical kaminer furansit	dical Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c.	the death. Do not e. a consequence of): a consequence of): a consequence of):	1	ng, such as cardia		st,	Approximate Interval Between Onset and Death
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After this funeral dir	ertification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not the		y 28b. Tim. Year) Injur	e of 28c. Injury Wo	her: 4 Nursing I	ath (Check only one Home 5 K Reside 28d. Describe ho	nce 6 Othe	ed .
4 hours after Funeral Dire- tely filled in by	edical Certif	4 Homicide determined	building, etc	c. (Specify) of my knowledge, desamination and/o	eath occurred at the trinvestigation, in my	ime, date and plac opinion, death occ	City or Town	u, State) ause(s) and mar	or Rural Route Number, nner as stated. nd due to the cause(s)
within 2 To the comple	Med	29b. Signature and title of certifie	fuzzma	nu	O DZ	se number 23683	29	9d. Date signed	(Month, Day, Year)
Sta		30. Name and address of person who STUARLA A. CR	completed cause of de	eath (Item 23a) (Ty (1) ar's Signature	pe. Print) HOPA	ins ale	LOGY G	nar	BACIMORE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Year Aug 10, 2004 Deakins Helen 12:30 am 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Cumberland Allegany Cumberland Nursing Home 8. Date of Birth (Month, Day, If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1□ M 2□√F Jun 7, 1918 214-07-4660 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Allegany Cumberland 1 □ Xes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Winifred Road 21502 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Xever Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Court System 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Leonard Franklin Deakins Ida Ethel (Boswell) Deakins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 241 Talcott Avenue Larry Abe nephew Frostburg MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Cremation 3 □ Removal from State Zion Memorial Park 8/13/2004 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Dnset and Death Immediate Cause (Final disease or condition resulting in death) moulto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of) Due to (or as a consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 45 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗆 No

or Attending Physicien: The law requires that the deeth certificete be executed for use es the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the oek within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the e completely filled in by the funeral director, page 2 should be detached it

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other then "natural; or Items 23a or 28e-f show ury or other treumetic event, it is Medical Examiner. Was two riditied at

Department of important: If it any injury or o

Physician

/Medical

Physician/Medical Examiner

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Completed

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Medical Certification: To

Examiner

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 deciritying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Da Afaquah maadar) M.D.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature 625 Kent Avenue Cumberland MD 21502

D0060478

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State of Maryland / Department of Health and Mental Hygiene 1- State Amend item 5 per fh g835 9-1409/tiffetate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Helen Downs Darrell 2004 AUGUST 6:58 AM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗙 F 82 Yrs. Director 9/12/1921 Delaware Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 'neturel', or Items 23a or 28a-f show dical Examinar must be notified at 1 XYes 2 No Director Del. New Castle Claymont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Winding Lane 19703 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Charles A. Downs Mary Knotts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5515A Lynch Lane, Baldwin, Md. 21013 David F. Darrell - Son item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 12 Cremation 3 ☐ Removal from State Summit Crem. Servi. 8/3/04 Wyoming, Del. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service L 22. Name and Address of Facility Matthews-Bryson Funeral Hm 123 W. Commerce St., Smyrna, De. 19977 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Physician disease or condition resulting in death) Lynutes /Medical Due to (or as a consequence of): Examiner artery Years ronary Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician 68760 Physician/Medical as the b Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 2000 Month 4 Pregnant at time of death 5 Other (specify) P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 20 No Division of Vital 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medicai (Check only and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 58303 AUGUST 1 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St Biltimae MD 21204 Advan J. Charles no 6601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2004 Registrar

DHMH 17 Rev 1/2001

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			1_ For	State	of Ma	aryland /	•	artment of H		Mental H		200	11.	25000
			Registrar 1. Decedent's Name (First, Middle	a Last)	_		Cei	uncale or L	Jeani	2. Date of I		. No.C. U	14	3. Time of Death
	Physicia	an			O					Month			Year	
	/Medic		4a. Facility Name (If not institution		OTHY	MAE	טט	TROW 4b. City, Town, or	Location of Dea		21.	4c. County of		9:05 P. ^M
	Examin	er	10631 TANEYTO					EMMITS				FREDI		7
-	Funeral		5. Social Security Number	6. Sex	7. Age	e (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs		3irth		9. Birtho	lace (State or Foreign
	Director		212-09-4560	1 □ M 2 🛛 F		89	Yrs.	Months Days	Hours Min	OCT .	Day, Y 15,	1914	Coun MAR	(LAND
	P		Usual Residence of Decedent											
	arylar ahow		10a. State 10b. County			10c. City, To	wn or Lo	cation					1	0d. Inside City Limits
	Sa-f (cto		ERICK		EMI	AITS:				,			1 ☐ Yes 2 ☒ No
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	er de item ner n	Funeral	11. Marital Status		Forces?		13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	to Rican, etc.)	No-		- Ameno , White,	an Indian, etc.
5	be filed within 72 hours after ital Hygiene. Id other then "netural", or ite event, the Medical Examina	by F	1 Never Married 2 Marri 3 XWidowed 4 Divorced	If Yas (40		1 ☐ Yes 2 ☒ No	Specify:			Specify:	WHI	TE
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2	be file tal Hyg d othe	Be C	17. Father's Name (First, Middle,	Last)					18. Mother's Na	me (First, Mida	lle, Ma	iden Sumame)	
	nouid b	To	JOHN THOMA	S WOOD					ROSA	A ED	ΙΤΗ	WEI	LER	
ar	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. Item 27 is marked other than "neturet", or items 23s or 28s-f show item 27 is marked other than "neturet", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relations	hip (Type, Print)		19	b. Mailir	g Address (Street a	and Number or R	ural Route Nun	ber, C	ity or Town, S	itate, Zip	Code)
Ξ.	s 1 and 3 f Health item 27 other tr	-,-	SUSAN STULTZ /	NIECE				3 TRACT R	D., FAIR		PA	. 17320)	
	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 DRemoval from	n State	20b. Place cemet	of Dispo ery, crer	sition (Name of natory or other place	9)	Date	20	c. Location - 0	ity or To	wn, State
	nit. Pages artment of ortent; If it injury or o		'4 □Donation 5 □ Other (S		Oldio	KEYS	VILI	UNION	8/9	/2004	KE	YSVILL	E, M	D.
	permit. Page Department of Important; If Imy injury or		21. Signature of Funeral Service	Licensee	1		22	. Name and Addres	s of Facility	SKILES	S FU	JNERAL	HOME	€
_	20199		John 1	n. Sku	les	,		210 W. MA	IN ST.,	EMMITS	oUK	s, MD.	2172	27
			23a. Page Enter the disease, or should, or heart failure. List	complications that only one cause or	t caused each lir	the death. Do	not ent	er the mode of dying	g, such as cardia	c or respiratory	arrest			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2 C'c.	NOES	TTVE 1	+842	IT MATCH	179					Onset and Death
	/Medical Examiner		resulting in death)			a consequence								
	LXAITIME		Sequentially list conditions,	b	RINA	any An	178	reg D1984	58					
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	and -tran	xarr	that initiated events resulting in death) Last	c	0 (01.35	a consequence	2 06):							
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0	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth	2 Fetal deat		Ectopic pregnancy Other (specify)				23d. Date Mont		ny Day Year
j	the d y the tched	lysi	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unk				(-,,/,						
7	that	by Pł	Part II. Other significant condition	ons contributing to	death b	ut not resulting	in the u	nderlying cause give	en in Part I.	23e. Die	d tobac	co use contri	ute to th	e cause of death?
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VII	sicien: The law s certificate has b lirector, page 2 s	e C	25. Was case referred to medica						26. Place of De	1 Yes		No 1	Yes	2 L No
	tending Physicien: leath. tor: After this certific the funeral director,	O B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatie	nt 2 ER/C	utpatien	t 3 DOA Othe	· · · · · · · · · · · · · · · · · · ·	Home 5 X Re		e 6 DOthe	(Specify	·)
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DIVISION	ar de recto	tifle	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inad 289. Pla	ce of Inju	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location City or 7			or Rura	Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the funer	edical	29a. Certifier 1X Certifyir (Check only 2 Medical	g Physician: To t	he best	of my knowled	ge, death	occurred at the time vestigation, in my op	e, date and plac	e, and due to th	e caus	se(s) and man	ner as st	ated.
	the hin 24 the F	Medi	one)	and ma	anner sta	ited.								
	Nit on one	-	29b. Signature and title of certifie	1-1	/			29c. License	number		29d.	Date signed	(Month, L	Dey, Year)
	1		Buyllo	If Me		フ		Mnoz	96 368		5	19/2	004	
	6		30. Name and address of person	who completed ca	use of d	eath (Item 23a) (Type,	Print)	1 11	->				
	- 0		31. Date filed (Month, Day, Year)	set, MO	Registra	ar's Signature	نكار	24/ 60	ethysbu	To la	<u> </u>	7325		
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			HUU T 0	LUUT /			~_	Mounts						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 5:30am Stanley 2004 Hanson Draper August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerford House Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1914 | Birthplace (State or Foreign (Months | Days | Hours | Min. | December | 24 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** X□M 2□F Director 215/26/7788 89 Yrs. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Iteme 23e or 28e-f ehow treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo MD Frederick Director Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13720 Stottlemyer Rd. 21783 U.S.A. by Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 3 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Farmer Farming Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill iment of Health and Mental H tent: If item 27 le marked ott Be Mae Hadessa Lewis Martin Luther Draper 19a. Informant's Name/Relationship (Type, Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6906 Greenvale Crt. Frederick, MD 21702 Emilline M. Zimmerman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ortent: Il 8/8/2004 Garfield, Maryland Garfield U.M.C.C. *4 □Donation 5 □ Other (Specify) permit.
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any nju 22. Name and Address of Facility Osborne Funeral Home 21. Signature of Funeral Service Licensee Moj414 425 S. Conococheague St. Williamsport MD 26a. Part1. Series the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cerebrovascular Accident disease or condition resulting in death) 24 Hrs. /Medical Las to (or as a consequence of): Examiner IO yrs. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter those yields Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran that initiated events physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 XNo 1 ☐ Yes 2 ☐ No 1□ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check on one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 x her (Specify) Assistant Living Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) o the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

Jy. MD 300 W.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Austin A. Pearre

D09689

8/7/2004

9th St. Frederick, Maryland 21701

, 3		1 - For State of Mary	-	artment of H			ene	
		Decedent's Name (First, Middle, Last)				2. Date of Deati	200	3. Time of Death
Physici /Medi		Donald Franklin Dill, S	r.			Aug. 5	, 2004	2:50 a ^M
Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	
	• ^	Stella Maris Hospice		Timon			Balt	
Funeral Director		5. Social Security Number 218-07-6189 Usual Residence of Decedent 6. Sex 1 ★ 2 ☐ F	9 yrs. last birthday) 87 yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 3,	^{Year)} 1917 N	Birthplace (State or Foreign Country) EW York
land ow			c. City, Town or Lo	cation				10d. Inside City Limits
Man 1 sh	tor	MD Baltimore I	White Ha	a11				1 ☐ Yes 2 🔼 No
th the or 28s)irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	at Country?
23a ust b	rai	19424 BurkeRoad		2116) <u>T</u>		USA	
ine, INIAI yiality Z.I.Z.I.Z.COOO	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Eve Armed Forces? 1 Wes 2 No If Yes, Give Year or Dates:	1941- '	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🎗 No	ispanic Origin? (S) n, Mexican, Puerti Specify:	pecify Yes or No- p Rican, etc.)		American Indian, White, etc. White
72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation	kina	6b. Kind of Busin	ess/Industry
Athin han a week	mple	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired				
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i, IVIC and 2 s ealth ar n 27 ls har trau	1	James W. Dill, Sr./Son		0 Dairy				
S 1 au of Heal		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place	e)	Date 2	t0c. Location - Cit	y or Town, State
Page Page nent c nnt: If ury or		1 ☐ MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Stabler Methodi	s United	∄ ¦Aug	.9,2004	Parkto	on, MD
partition, permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Signatura runaral si vice Licensee	22	2. Name and Addres	ss of Facility J.	J.Harte New Fre	nstein edom, I	Mortuary,In PA 17349
		23a. Fart1 Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	ICER					Onset and Death
/Medical Examiner		resulting in death) Due to (or as a co	onsequence of):					
	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a co	onsequence of).					
uted F insit	i.	cause. Enter Underlying Cause (Disease or injury	,					
exection and ial-tra	Examiner	that initiated events c Due to (or aş a co						
of ou, sate be executed bhysician and the burial-transit	Icai	d	· · • • • •					
rtifica ng ph		IF FEMALE:						
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time past 12 months? 4 ☐ Pregnant at time p	Fetal death 3	Ectopic pregnancy Other (specify)	`		23d. Date o Month	f delivery Day Year
res that the de signed by the a		Part II. Other significant conditions contributing to death but n	nt resulting in the u	nderlying cause give	an in Part I	23e Did tob	acco use contribu	ite to the cause of death?
law requires t as been signe 2 should be o	ted by	Takin and against an against a said a said again said in	or resulting in the di					Probably 4 Xinknown
The The ate h	Completed					24a. Was ar autopsy perform 1 Yes 2	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No
OI VICAL Phyaician: 'rthis certifica	Be	25. Was case referred to medical examiner?		100		th Check only one	_	
a this	10	1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatier		4 Nursing H	ome 5 Reside		Specify) HOSPICE
fter mer	ertification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Yell)	ear) 28b. Time of Injury	Work	/ at ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
Attanding Attanding of death. actor: After by the fune	lical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury	At home, farm, str		163 2 140	28f. Location (Str	eet and Number o	or Rural Route Number,
al or At after of Dirac d in by	erti	4 Homicide determined 259. Flace of injury building, etc. (3	Specify)	Ton reality amou		City or Town	State)	/
To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of manual per stated and manual per stated	amination and/or in	h occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)
To th Mithin To th	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (A	fonth, Day, Year)
4.		/ 4, -		1)	4372		815	164
11/1		30. Name and address of person who completed cause of death	n (Item 23a) (Type,	Print)			/-/	
7				LLEY RD.	TIMONIUM	MD 2109	3	
	ate	31. Date filed (Month, Day, Year) 32. Registrar's		books	-			
Regist	rair	AUG 1 3 2004 Sene	1 Pop	JOHNS	-			

DHMH 17 Rev 1/2001

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AUGUST 5, 2004

DONALD DILL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JULY 21, 2004 SALLIE K. ELLIOTT 3:20pm /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday)

84 Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug. 1, 1) 5. Social Security Number 9. Birthplece (State or Foreign **Funeral** 1 ■ M 2 😿 F 226-12-8886 1919 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Exprisher must be notified at WDC WASHINGTON D.C. 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 900 Varney ST SE Apt. 334 20032 United States of America or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11, Marital Status Black, White, etc. Black within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 🗆 Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced 'naturei' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7th grade College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importent: If item 27 ie marked other th any injury or other traumation. Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be John Elliott Lillie Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Major Elliott / Brother 4609 Mannasota Ave. Baltimore, MD. 21206 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Maryland Ntl. Cemetery 7/27/04 Laurel, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Fyneral Service Licenses once 716 Kennedy ST NW WDC 20011 23a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Blander Cancer **Physician** disease or condition resulting in death) /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and I for use as the burial-fransit the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 3 Probably 4 Unknown 2 1 No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No ector. 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 2 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Division 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely f within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOBEKT F. BL 11161 NEW HAMPSHIRE AUE. SILVER SPRING, M. 20904 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 3 0 2004 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stata Registrar Per Phy 7/28/04 Certificate of Death Amended #26 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** Pauline **Evans** July 25, 9:35 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1910 Waesche Place Mitchellville Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, NOV 19, 9. Birthplace (State or Foreign **Funeral** Months 005-12-5068 1 □ M 2 1 F 85 Yrs. Director Ireland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or than "natural", or Items 23a or 28e-f show the Madical Examinal must be notified at 1 Yes 2 □ No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9413 Jones Place 20706 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Maxical Examiner must) once. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ð 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mark Geaghan Julia Clancy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Patricia Evans-Nuth (Daughter) 1910 Waesche Place, Mitchellville, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 7/30/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signatur of Fineral S ice Licengee 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only goe cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Cerebravasculeof eccolera Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the buriai-P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by d be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Horte Apdominal Aneumon 1 ☐ es 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 21421212-24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death Check on one Other: 4 Nursing Home 5 Passe 1 ☐ Yes 2 ☑ No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ÷ 6 v Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After

Division of Vital the Hospitel or Attending Physician: death.

Director: / hours after within 24 hours a To the Funeral C ٩ N

31. Date filed (Month, Day, Year) State 2004 28 Registrar

1 Natural

2 Accident

3 Suicide

29a. Certifie

Medical

4 T Homicide

(Check only one)

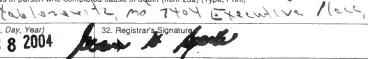
29b. Signature and title of certifier

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D 25

29c. License number

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

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			1 - For State Registrar	State of M	faryland	•	artment of H rtificate of		nd Mental I	Hygier Reg. 1	OOGI	25914
	Physici /Medio		Decedent's Name (First, Middle, La KAREN ECI	HERE					2. Date of Month July		Day Year 2004	3. Time of Death 5:00 A M
	Examin	er	4a. Facility Name (If not institution, given the Advention)	tist Hospi	tal		****	a Park	c		4c. County of Death Montgome:	
	Funeral Director			Sex 7. A 1 ☐ M 2 🖫 F	Age (In yrs. la	37 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of (Month) June			place (State or Foreign ntry) hington, D.
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show spiring or other treumatic event, the Medical Enaith at Innal Le Indillia of an once.	/ Funeral Director	10a. State 10b. County D. C. — 10e. Street and Number 4904 Quarles St. 11. Marital Status 1 Never Married 2 Married	N.E. #1 12. Was Deceder Armed Forces 1 Yes 2 5 If Yes, Give	Was		on 10f. Zip Code 20019	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.	Ur	Citizen of What Counited State 14. Race - Ameri Black, White,	tes can Indian,
ld 21215-0036	filed within 72 hours Hygiene. other than "naturel", ent, the Medical Ere	e Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Las	Year or Dates ducation ade completed) College (1-40		16a, Deced	dent's Usual Occup kind of work done DO NOT use retired	eation during most d) Nurse	of working S Aid 's Name (First, Mic		Specify: Blac Kind of Business/Ir	
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8760,	death certificate be executed e attending physician and for use as the buriat-transit	dical Examiner	23a. Part . Enter the disease, or conshork, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it is a failure of the cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Sersis Due to (or a		Donbt ent						D.C. 20002 Approximate Interval Between Onset and Death
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9	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions	contributing to death	but not resu	iting in the u	ndertying cause giv	en in Part I.			o use contribute to t 2 XNo 3 ☐ Prot	he cause of death?
of Vital Records,	The law ate has b page 2 si	Completed								utopsy erformed?	prior to co death?	opsy findings available impletion of cause of
	Attending Physicien: r death. sctor: After this certific by the funeral director,	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	28a. Date of In (Month, D	tient 2□E ijury Da <i>y Year)</i>	ER/Outpation 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nurs	28d. Descri	esidence	6	(y)
Division	i Sign	Certification;	3 Suicide 6 Could not lead to determine determined	286. Place of I	njury - At ho etc. <i>(Specify</i>		eet, factory, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Rura ate)	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) Certifying P Medical Exa	hysician: To the bes miner: On the basis and manner:	of examinati	wledge, death ion and/or in	n occurred at the tirvestigation, in my o	ne, date and pinion, death	place, and due to to occurred at the tin	the cause) ne, date a	(s) and manner as s nd place, and due to	tated. o the cause(s)
)	Tot Tot Com	M	29b. Signature and title of certifier 30. Name and address of person who	ID ID	f death (item	23a) (Tvoe	29c. Licens			1	Date signed (Month,	Day, Year)
	Sta Registi		Dr. Irfan Khan 31. Date filed (Month, Day, Year) 2 8 2004	7600 Car		Ave.,	Takoma Pa	ark, M	d. 20912			

				State of Ma	-	Certificate of		_	giene Reg. No?	14 25915
П	Dhysiair		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	eath Day	3. Time of Death Year
	Physicia /Medic		ETHEL MAY ELLIS					JULY	23,	2004 6:40AM
· Sanda	Examin		4a Facility Name (If not institution, giv	e street end number)			4b. City, Town, or	Location of Deat	h 4c. County	of Death
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i	Funeral Director		5. Social Security Number 6. S 579 24 3479 Usual Residence of Decedent	ex 7. Ag	e (In yrs. last birti	Months Days	Hours Min.	(Month, De	3, 1919	9. Birthplace (State or Foreign Country) WASHINGTON, DC
	puel *		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
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	r 28e	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	h wit	a D	8101 D'ARCY ROAD			20	747		UNITE) STATES
	deal	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.	13. Was Decedent of I If Yes, specify Cub	lispenic Origin? (S	pecify Yes or No		e - American Indian, k, White, etc.
Maryland 21215-0020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes ŽŽŽI If Yes, Give Year or Dates:	No	1□Yes XXNo				BLACK
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ē,	f Hea f Hea tem	-	20a. Method of Disposition		20b. Place of	Disposition (Name of y, crematory or other ple		Date		City or Town, State
Baltimore,	permit. Pages Depertment of I Important: If ite any injury or or pnce.		12 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special Control of the Contr	(y)		HILL CEMET	ERY	7-27-04		AND, MD
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Division	l or Attence after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Place of in	ury - At home, fa c. (Specify)	rm, street, factory, office			(Street end Numb own, State)	er or Rural Route Number,
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	To the within 2 To the comple	M	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date signed	d (Month, Day, Year)
	. 4	2	Daniel.	Snow	y M	D45	533		JULY 2	23, 2004
-	CR 10		30. Name end address of person who DANIEL SNOW, M.D.	•		(Type, Print) 9703 EXECUT	TVE PARV	CIRCIF	СЕДИ	ANTOWN, MD 20874
	01		31. Date filed (Month, Day, Year)	1	ar's Signature	JIOJ LABOUL	TAT TUIVE	OTKOLE	GERIL	MIOWN, FID 200/4
	Sta Registi		JUL 2 9 2004	Been		antes				
Di	MU 16 Day 6M	-		1-4-4-	- 1					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 8:33 am Jeanne Keith Everhart 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Mar. 15, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Wash., 1 M 2 KF 577-32-2327 Director Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 □Xes 2 □ No Director Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4009 Yarmouth Lane 20715 USA or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates: 1 Never Married 2 XMarried Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in the and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Bowie State College 12 Data Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon Irene Ansalen Snow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is eny Injury or other treu <u>once</u>. William Everhart, Sr./spouse 4009 Yarmouth Lane Bowie, MD. 20715 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crem. 8-4-2004 4 □ Donation 5 □ Other (Specify) Alexandria, VA. 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. Bowie, MD. CI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** estrictive /Medical Due to (or as a consequence of): **Examiner** Dolio Post if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 ☐ Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 ☐ Yes 257 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide

Hospitel or Attending Physicien: Division 24 hours a

State

within 2 To the

29a. Certifier

29b. Signature and title of certifier

30. Name and address g

Medical

CALCANT 143 00 31. Date filed (Month, Day, Year) 3 0 2004

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

sigh

Registrar

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D45660

DPINDER SINGH. M.D.

c Cui

29d. Date signed (Month, Day, Year)

7-29-04

20711

			1 - For State Registrar	9	State of I	Maryland	d / Depa		t of H	lealth and N Death	/lental Hy		2001	259	917
			1. Decedent's Name (First, Mic	ldle, Last)							2. Date of De Month	ath Da	y Yea	3. Time	of Death
	Physici /Medio		Marion	Eyı	re						July	28			0 P ^M
?	Examin		4a. Facility Name (If not institut	ion, give stre	eet and numb	er)		4b. City,	Town, or	Location of Death		40	County of De	eth	
			8303 Glen Hea	ther	Drive			Fred	lerio	ck		E	rederi	ck	
	Funeral		5. Social Security Number	6. Sex	7.	Age (In yrs. Ia	ast birthday)	ff Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da			lirthplece (Stete Country)	or Foreign
	Director		217-44-3611	1 1 1	XXF	59	Yrs.	Months	Days	TIOUTS MILL.	January	14,1	945 Ne	w York	
	P >		Usual Residence of Decedent			10- 0:1	7								
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	the Maryla 28a-f sho	ctc		lerick		Free	derick							1 1 10	s 2/X/No
		Director	10e. Street and Number					10f. Zip	Code			10g. Cit	izen of What	Country?	
	23a	rai	8303 Glen Hea	ther	Drive			217	02_			Uni	ted St	ates	
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36	a o	Ϋ́F	1 Never Married 2000M		1 ☐ Yes X	No		ı □ Yes X		Specify:			Specify:	White	
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12	within ene. then	ш	Elementary/Secondary (0-12)	College (1-4)	or 5+)		DO NOT us		,					
	be filed witt ital Hygiene id other the event, the		17. Father's Name (First, Middle	o (act)			Adiii1	nistr	ativ	7e Office				s Govern	ment
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3	should be ad Menta marked matic ev	10	Russell Sheer				.2			Marion M					
Maryland	2 m m		19a. Informant's Name/Relatio				19b. Mailir	ng Address	(Street a	and Number or Ru	ral Route Numbe	er, City o	or Town, State	, Zip Code)	
	s 1 and of Health item 27 other tr		Lewis Eyre/ H	lusban	d	ach Bu				ather Dri					702
Baltimore,	uges 1 nt of the interest in ite		20a. Method of Disposition XXBurial 2 ☐ Crematio	n 3∐Ren	noval from Sta	0.0	ace of Dispo metery, crer	natory or o	ne or ther plac	e)	Date	20c. L	ocation - City	or Town, Stete	
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a	permit. Pages Department of I Important: If it any Injury or o		21. Signature of Funeral Servi	e Ligensee	~	11	• 22	. Name an	d Addres	ss of Facility St	auffer	Fune	ral Ho	mes, P.	Á.
ш	205 20		Marow	Cun	elle	Clus	ve 1	621 0	poss	sumtown P	ike/Fre	deri	ck, Mar	yland 217	702
			23a. Part1. Enter the disease, shock, or heart failure. L	or complica	tions that cause on each	sed the death.	Do not ent	er the mode	e of dyin	g, such as cardiac	or respiratory a	rrest,		Approxima Interval Be	ate etween
1	Physician		Immediate Cause (Finat disease or condition	-	OV	ARIA	V	CANO	CCR					Onset and	
	/Medical		resulting in death)			as a consequ								16114	0.4.10
/	Examiner		Conventially liet conditions	ь											
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to (or	as a consequ	enca of).								
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68	leath certificat attending phy i for use as th	ledi		_		-									
Вох	h cer andir use	Physician/Med	fF FEMALE: 23b. Was decedent pregnant	23c	. If yes, outcom	me of pregnan 2 □ Fetel)C-1					23d. Date of d	lelivery	
	deati e atte	icia	in the past 12 months? 1 ☐ Yes 2 XNo		4 Pregnan	at time of de		Ectopic pro Other (spe					Month	Day	Year
0.	at the de by the a tached	hys	9 □ Unknown		9□ Unknow	1									
σ.	The law requires that the death certifica te has been signed by the attending ph hage 2 should be detached for use as It	by P	Part II. Other significant cond	itions contri	buting to deat	h but not resu	iting in the u	nderlying ca	ause give	en in Part I.	23e. Did to	obacco (se contribute	to the cause of	death?
ĕ	quire n sig ald b										101	Yes 2	□No 3□	Probably 4 🔀	Unknown
Vital Records,	w requir s been si should	Completed									24a. Was	an	24b. Were	autopsy findings	s available
Re	The lav	m C									autop	rmed?	prior to death'	completion of	cause of
2		Ö	25. Was case referred to medi	nal	·							25 No	1 U Yı	es 2 No	
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o		-	27. Manner of Death		28a. Date of I	niury	28b. Time of		A	4 Nursing H	ome 5 Residence 1			oecify)	
OU	ding h. h. After funer	tior	1 ANatural 5 Pen 2 Accident inve		(Month,	Day Yeer)	Injury	м	8c. Injury Work	k? Yes 2 □ No			,		
Division of	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be	28e. Place of	Injury - At hor	me. farm. str	eet factory			28f Location /	Street an	nd Number or	Ru <i>ral R</i> oute Nur	mher
<u>S</u>	after Dire	erti	4 ☐ Homicide deta	mined	building,	etc. (Specify))	oot, lactory	, omos		City or Tov	vn. State)	igrai / rodie / vgi	111201,
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	Hos 24 h Fun Fun	edical	(Check only 2 Medic	al Examine	r: On the basi	s of examinati	on and/or in	estigation,	in my of	pinion, death occur	red at the time,	cause(s) date and	i and manner. I place, and di	as stated. ue to the cause((s)
	To the Hospitel or Attivition 24 hours after de To the Funeral Direct completely filled in by the	Med	29b. Signature and title of certi	fier	www.manner	June Grand G		29c	. License	number		29d Da	te signed (Mo	nth, Day, Year)	
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			_ to the	9 JU	en,	/ (/		1	14-	7107		- '	1271-	2004	
-	P		30. Name and addr as 1 person	n who comp	pleted cause of	death (Item	23a) (Type,		UL	PLACE		A1-T	MART	2004 MD 2	
			31. Date filed (Month, Day, Ye.	1/1/1	117	XX'	87.	PM	N.L.	PLACE	- 5/	14-1	11.cour	110 2	1202
	Sta		31. Date filed (Month, Day, Ye.		200/L	strar's Signati	ure	9	1	a. W. /					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended, #11, F.H., 8/6/04, sbb State of Maryland / Department of Health and Mental Hygiene Amended, #26, per M.D., TCHD, 07/30/04, sbb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Ju1y ANN 27 2004 7:05a GLORIA EGERSON /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 27 Linbrook Court Talbot Easton If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 K F Yrs. 217-44-1494 **Director** 57 Mar.24.1947 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23e or 28e-f ehow 1 ☐ Yes 2 1 No Directo Talbot Maryland Queen Annes 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 13065 Lewistown Road 21657 USA filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1☑ Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 28 No Specify δ -3Æ Widowed -- 4 □ Divorced Black Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Certified Medince Aide Genesis Elder Care event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pegas 1 and 2 should be and Mental marked James Roy Egerson, Sr. Mary Louise Thomas 19e. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Health 8 Tina Saddler / Daughter 27 Linbrook Court, Easton, Maryland 21601 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of ortant: If it injury or 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/31/04 Easton, Maryland Woodlawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home ummie 426 Dover Street, Easton, Maryland 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examine The law requires that the death certificate be axecuted buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury Due to (or es e consequence of) P.O. Box 68760, Physician/Medicai that initieted events resulting in death) Last Due to (or as e consequence of) the s USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? cartificate hes t lirector, pege 2 s 1ces 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) daughter's Hospitel: 1 Inpatient Other: 4 Nursing Home Statestoence 6 Other (Special Sidence 2 1 Yes 2 No 3□ DOA 2 ER/Outpatient this funaral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A complataly filled in by tha fu 1 ☐ Yes 2 ☐ No 2 Accident 3 [7] Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. å

State Registrar

29b. Signature end title of certifier

31. Date filed (Month, Dey, Year)

Jennifer Hollywood

JUL 30

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

538 Cynwood Dr. Easton, Md.

29c. License number

D46820

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2004 **Physician** 1818 July EASON WILLIAM /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly
If Under 1 Year | If Under 24 Hrs. HOSPITAL PRINCE GEORGE GEORGE'S PRINCE Sex 14⊡XM 2□F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Yrs 17,1918 Maryland Director 579-09-5573 Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. Slate 10b. County r then "natural", or items 23s or 28s-f show the Micigal Examinar must be notified at 1XYes 2 □ No Director Richmond Virginia Richmond 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23328 USA 4903 Beaver Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, While, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Government Clerk permit, Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eason Alexsine Unknown ပ William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4903 Beaver Lane, Richmond, Virginia Eason / wife Estelle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State

¹ 4 Donation 5 Other (Specify) 07/31/2004 Trappe, Maryland Paradise Cemetery 22. Name and Address of Facility
Pennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle, Other: Hospital: 2 X ER/Outpatient 1 Yes 2 No 1 Inpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner example. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier dela tho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 32. Registrar's Signature 31. Date filed (Month State Registrar

ORIGINAL

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		1 _ For State	State of Marylar	•		_	200	1 0-
		Registrar	0.04)	Certific	ate of Death	2. Date of De.	Reg. No. /	3. Time of Death
Physic	ian	Decedent's Name (First, Middle, L.	•	TITLE		Month	Day Yes	ar M
/Med		DALTON 4a. Facility Name (If not institution, g	ALLEN		ARDS Dity, Town, or Location of De	AUGUST	8, 2004 4c. County of D	4:10P. "
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pu ,		Usual Residence of Decedent	10a Ci	ty, Town or Location				10d. Inside City Limits
aryla shov	7	10a. State 10b. County		ty, rowir or Location		. 7 7		1 ☐ Yes 2 🛣 No
the M	ecto	MD. Ha	rford	10	White Ha	411	10g. Citizen of What	
with	Š	4300 Norrisv	ille Road	10	2116	1	United	
1215-0036 within 72 hours after death with the Maryland ane nne. then 'netural', or items 23e or 28e-f show then Majical Examiner must be notified at	Funeral Director	11. Marital Status	12 Was Decedent Ever in I	J.S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu			merican Indian,
or iter	F	1X Never Married 2 ☐ Married	Armed Forces?	1		erto Hican, etc.)		hite, etc.
ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	104	es 2 X No Specify:		Specify:	White
21215-0036 od within 72 hours af giene. er then "netural; or i, the Mudical Ex. m	Completed	15. Decedent's (Specify only highest of	Education grade completed)	16a. Decedent's (Give kind o	Usual Occupation f work done during most of T use retired)	working	16b. Kind of Busine	ss/industry
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Hygie thers	ပိ	17. Father's Name (First, Middle, La	st)	1		Name (First, Middle,		rrege
yland 212 uld be filed with Mental Hygiene. arked other the	o Be	Allen	Eugene	Edwar		nna	Marie	Kelly
Maryland d 2 should be file th and Mental Hy it is marked oth treumatic event	J.	19a. Informant's Name/Relationship			ress (Street and Number or			
C = 64 F	1.	Allen E. Edw	ards/Father		orrisville		hite Ha	
Baltimore, permit. Pages 1 ar Department of Hea mportent: If item any Injury or othe		20a. Method of Disposition	20b.	Place of Disposition cemetery, crematory	(Name of or other place)	Date	20c. Location - City	or Town, State
Page:		1			ends Cem 8,	/14/04	Rallston	n. Marvlan
Baltimo permit. Page Department of Importent: If eny Injury or		21. Signature of Funeral Service Lie			e and Address of Facility			
a gg = 2 g		111. Duce	den Turk	Ja	rrettsville	e. Marvl	and 210	084
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the ba	th. Do not enter the	mode of dying, such as care	liac or respiratory a	rrest,	Approximate Interval Between
Priysiciai		Immediate Cause (Final disease or condition	NVLTIPLE 1					Onset and Death
/Medica Examine		resulting in death)	Due to (or as a conse	quence of):				
Cxamme		Sequentially list conditions,	b					
Si ed	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence oi):				
60, be executed ician and burial-transit	Examiner	Cause (Disease or Injury) that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):				
760, te be ex ysician	calE		d.					
687 tificate I			0.					
Box 68 leath certificate attending phy for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn				23d. Date of	delivery
death death of for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fet		pic pregnancy or (specify)		Month	Day Year
P.O. I that the de ed by the a detached f	hys	9 🗆 Unknown	9□ Unknown					
Records, P.O. Box 68 The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as if	by F	Part II. Other significant condition	s contributing to death but not re	sulting in the underly	ing cause given in Part I.			e to the cause of death?
cord * require been si						_ 10	Yes 2⊠No 3□	Probably 4 Unknown
law re as be	ple					24a. Was	prior prior	autopsy findings available to completion of cause of
	Completed						ormed? death	n? Yes 2□ No
vision of Vital Records, Attending Physicien: The law requires t death. ector: After this certificate has been signe by the funeral director, page 2 should be e	Be	25. Was case referred to medical examiner?	Hoonitals		Other	Death (Check only o	one)	
	2	1 XYes 2 No		ER/Outpatient 3			dence 6 Other (S	Specify)
Division of lor Attending Phy- after death. Director: After this in by the funeral d	Certification;	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury To UNIMONTH, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 🗷 No	SVBTECT	How injury occurred	ROM VEHILLE
isic ttend death ctor:	licat	2 Accident investigat 3 Suicide 6 Could no	t be Rea Bloom of Injury At I	home, farm, street f	actory office	28f. Location (Street and Number o	r Rural Route Number,
Division of the north of the state of the st	ertif	4 Homicide determin	building, etc. (Spec	eify)	otory, office	City or To	wn State)	D, HARFORD, HO
DIVISIO To the Hospitel or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying	Physician: To the best of my kr	nowledge, death occ	urred at the time, date and p			
24 h e Fur	Medical		caminer: On the basis of examinand manner stated.					
To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License number		29d. Date signed (M	onth, Day, Year)
		> Quel	_		O.C.M.E.	i	AUGUST 9,2	004
6		30. Name and address of person w		em 23a) (Type, Print				
		ANA RUB	10,40		Penn Street	, Baltimo	re, Maryla	ind 21201
	tate	31. Date filed (Menth, Day, Year)	2004 32. Registrar's Sign	pature	sporks			
Regis	trar	TOUT O	/ -	,				

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FUNERAL DIRECTOR

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COMPLETED

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PHYSICIAN: MEDICAL CERTIFICATION

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FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND / DEPAR Certif	RTMENT OF	HEALTH	AND I	MENTAL HYGIEN		00	4 259	21
1. DECEDENT'S NAME (First, Middle, Last) Charles Mur	ay Ey	er				2. DATE OF DEATH DA AUGUST 10		00 ^{YEAR}	3. TIME OF DEATH 9:25P	м
4. SOCIAL SECURITY NUMBER 219-20-0446	5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR	-	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 29, 19	925	Counti	HPLACE (State or Foreign ry) aryland	n
9a. FACILITY NAME (If not institution, give	96. CITY, TOW	N OR LOCATIO	N OF DE	EATH	9c. COL	COUNTY OF DEATH				

Dennett Road Manor Nursing Home 0akland Garrett RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Garrett 0akland 1 YES 2 X NO 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 236 Lake Shore Dr. 21550 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \(\) YES 2 \(\) NO IF YES, GIVE WAR OR DATES 1 943-46 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puarto Rican, efc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 3X Widowed 4 Divorced Specify: White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only his mfg. stair materials/ College (1-4 or 5+) owner/operator/carpenter cabinet construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Murray Eyler Alice Selby 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Coda) Dean M. Eyler/ son 236 Lake Shore Dr. Oakland, MD 21550 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Ran 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE All County Cremation Serv. 8/12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. NAME AND ADDRESS OF FACILITY Hartzler Funeral Home 21. SIGNATURE)OF FUNERAL SERVICE LICENSEE 6 E. Broadway Union Bridge, MD 21791 23. PART I. Enter the diseases, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death . Atheroscleropic cardiovascular disease disease or condition resulting in death) 4R) chronic osstantive pulmonny disease 4RS Sequentially list conditions. if any, leading to immediate CONSEITIVE heart
DOE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING 4 RJ CAUSE (Disease Dr injury that initiated events resulting in death) LAST Alzheimers 4RS PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ZE'NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) QTHER: 1 TES 2 XNO 1 Inpatiant 2 ER/Outpatient 3 DOA Nursing Home 5 Realdance 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be detarmined 4 Homicida 1 DECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) end manner as stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner ea stated. 296. SIGNATURE AND WILE OF CHITIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) mald 030035 08/10 104 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ONALD RICHTER MIS 1533 MEMORIA DRIVE OAKCANO MO 21550 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Zanersa AUG1 8 2004

				State of I	Maryland /		tment of <i>ificate o</i> i		nd Mental I	Hygiene Reg. No.2	104 25	1922		
	Physic	ian	1. Decedent's Name (First, Middle,	Last)						2. Dete of Deeth Month Day Year 3. Time of Death				
-	/Medi		Annis V	irgina Fei	st				7	24	04 /11	30AM		
	Exami	ner	4a. Facility Name (If not institution, 13503 Coldwater	give street end numbe Drive	er)			•	n, or Locetion of D AShington	Locetion of Death 4c. County of Deeth Prince George's				
Н	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last		If Under 1 Yea	r If Under 2						
	Director		578-14-9129	^{1□M} 20 F 8	6	Yrs.	Months Day	Hours	Min. (Month 4/6/	Birth Dey, Yeer) 1918	9. Birthplace (St. Country) Virginia			
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c City To	own or Loca	tion				404 leafe	de Oibel inside		
	with the Merylend a or 28a-f show be notified at	ō		George's			ington					de City Limits Yes 2 No		
	r 28a	rec	10e. Street end Number				10f. Zip Code			10g. Citizen of	f What Country?			
	th wit	aj D	13503 Coldwater	Drive				2074	. 4		USA			
	r dea	ne	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U,S. s?	13. Wa	as Decedent of es, specify Cu	Hispanic Origi ben, Mexicen,	n? (Specify Yes or Puerto Ricen, etc.)	No- 14. Ra	ace - American India ack, White, etc.	n,		
20	72 hours efter death with the Merylend netural', or Items 23a or 28a-f show fical Examiner must be notified at	Completed by Funeral Directo	1 ☐ Never Married 2 ☐ Marrie 3(☐) Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	XNo		□Yes 2Ū(No				my: White			
9	2 hou etura	Ted It	15. Decedent's	Education		6e. Deceder	nt's Usuel Occi	pation		16b. Kind of I	Business/Industry			
215	ithin 7	pje	(Specify only highest Elementary/Secondary (0-12)	grede completed) College (1-4o	r 5+)	(Give kir life. DC	nt's Usuel Occu nd of work done O NOT use retir	e during most o ed)	of working		· · · · · · · · · · · · · · · · · · ·			
121	led w tygien her th	ខ	12th	-41	He	omemak	cer				At Home			
anc	d be fi	Be	17. Father's Name <i>(First, Middle, Le</i> Middleton Ha	artlev				Julia	s Name (First, Mid Kible		me)			
Maryland 21215-0020	should nd Me mark imetic	2	19a. Informant's Name/Relationshi		1	9b. Mailing	Address (Stree				n, State, Zip Code)			
	alth e alth e 27 is er trei		Susan F. Bartle		r i	13503	Coldwa	ter Dri	ve Ft. W	ashingto	n,MD.2074	4		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death w Depertment of Health and Mental Hygione. Important: If item 27 is marked other than "netural", or items 23a in hiury or other treumatic event, the Medical Examiner must once.		20a. Method of Disposition 1 X Burial 2 ∠ Cremation 3	□ Removal from State	On ma		ion (Neme of tory or other pla	ace)	Dete		- City or Town, State			
ij	permit. Pages Depertment of H Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Spe	cify)	Ft.		In Ceme	_	£	1	ood,Maryla	and		
Bal	Deperiment Deperiment Important In Sun In Su		21. Signetur of Funeral Service Li	censee					George K ld. Oxon		eral Home			
			23a. Part1. Enter the disease, or co	as b										
1	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death)	e	fenos	/en	pic c		19sulan		Onset e	imate Between end Death		
2	ificete be executed g physicien end es the buriel-transit	Examiner	b. Due to (or as a consequence of): if any, leeding to immediate											
68760,	sicien burie		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that in flated events	C.			an Contractor							
89	** D 0	ledicai	resulting in death) Last		Due to (or as	a consequer	nce ot):							
Вох	eeth certifi ettending for use es	an/N		■ d										
Э. Н	The lew requires thet the death cert ate has been signed by the ettendin page 2 should be deteched for use	Physician/N	Part II. Other significant conditions	contributing to death	but not resulting	in the unde	erlying cause g	ven in Part I.	23b. D	id tobacco use co	ontribute to the cau	se of deeth?		
P.0	thet the de ed by the deteched		PIMI ~	rognist	man	away	M		1	□Yes 2100	3 Probably 4	Unknown		
Vital Records,	signed ld be de	d by	2000		0	0) 0			240 100		24b. Were autop	any findings		
CO	v require been si should I	Completed							24a. vv pe	as en autopsy erformed?	evailable pri	ior to		
Re	The few cate has page 2 a	ошо							41	□Yes 2X No	of death?	•□ N-		
		BeC	25. Was case referred to medical					26. Place of	f Death (Check on		1 ☐ Yes 2			
of <	Z 20	To	exeminer? 1 ☐ Yes 2 📉 No	Hospital: 1 Inpat	tient 2 ER/0	Dutpatient	3□ DOA Ot	hor:	ing Home 5/12 Re		ner (Specify)			
n c	ding Ph. h. After th funeral	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Dete of In (Month, D	ury 28b ay Year)	. Time of Injury	28c. Inju Wo			e how injury occur	rred			
Division	the the	icat	2 Accident investigat 3 Sulcide 6 Could not	be on Diseased to	aium. At home	form street		Yes 2□No		(Chroat and Misson	D / D A	b b		
≦	Il or Attend efter death Director: / d in by the	Certification:	4 ☐ Homicide determine	building, e	njury - At home, etc. <i>(Specify)</i>	rami, street	, тастогу, оптов		City or	rown, State)	ber or Rural Route N	iumber,		
	Hospita 14 hours Funeral tely fille	ledical C	29a. Certifier (Check only one)	Physician: To the besi aminer: On the besis and menner s	of examination a	ge, death oc and/or invest	ccurred et the ti tigation, in my	me, date end popinion, death	place, end due to the control occurred et the time	ne ceuse(s) end m e, date and place,	enner es steted. and due to the ceus	se(s)		
	To the To the comple	Me	29b. Signature end title of certifie				29c. Lilcon	se number		29d. Date signe	ed (Month, Day, Yeer	r)		
			1	•				1943	/	7/24	1/04			
0/	(12)		30. Name end eddress of person yet	o completed cause of	death (Item 23a) (Type, Prin	nt)	117	71.1	-d-\1	10 3.0	111		
4	1 (19)		31. Dete filed (Month, Day, Year)	you my	trar's Signature	44	NJ/10~	14L T	1. Wash	ng row	W 2010	14		
	Sta Registra	re	1111 2 8 20		Lar a Gigilature,	land								

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

11701 LIVINGSTON RD. #103 FT. WASHINGTON, ND 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

FRANK M. RYMI.

JUL 2 9 2004

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 29, 204 Day 1:15 PM **Physician** Elizabeth Ann Ferguson July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution-give street and number) Examiner Hospital of Baltimore Baltimare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□M 2XF Virginia 227-34-3844 July 17, 1930 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 23a or 28a-1 show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-4 show any injury or other traumatic event, If a Mcdical Examinatic sust be notified at 1 ☐ Yes 2 XNo Dorchester Cambridge Director MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21613 U.S.A. 5552 Bonnie Brook Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: Specify: white δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) secretary electronics mfg. 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Slough Douglas Rupert Ezra Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5552 Bonnie Brook Rd., Cambridge, MD 21613 husband Roy E. Ferguson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 8/3/04 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur of Funeral Service Licensee 700 Locust St., Cambridge, MD We legger 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Physician Vulvav /Medical Metricillin Resistant Staphylococcis Arvers Endocarchis Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe death? 1 ☐ Yes 2 Z No 2 2 No after death.

Director: After this certific
In by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA ို 28d. Describe how injury occurred 28b. Time of 27. Manger of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide within 24 hours a

To the Funerei C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES OOD M.D. 30. Name and odde as of person who completed cause of death (Item 23a) (Type, Print) Hospital of Baltimore Ballard miD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

DHMH 17 Rev 1/2001

Elizabeth Fengus on

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Edward Ford, Sr. Raleigh Ju_{1y} 2004 12:40p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George Clinton Southern Maryland Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Yrs. Director 75 14, 1928 Washington, DC Oct. 579-34-0695 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c, City, Town or Location 10a State 10b. County 77 is marked other than "natural", or Items 23e or 28e-f show treumatic event. The Medical Exercities in District Heights 1X Yes 2 No Maryland Prince George Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20747 1908 Glendora Drive death Funeral yiand 21215-0036

y yiand 2 should be filed within 72 hours after dea.

Nament of Health and Mental Hygiene.
Imporent: If item 27 is marked other than "natural" ..."

eny injury or other treumatic event. 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰Yes 2 □ Nd /24/51 If Yes, Give Year or Dates: 1/12/53 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Specify: ð 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Government Lithographer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth P. Bell Frank Francis Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 Thornknoll Dr. Ft. Washington, Md. 20744 Terry R. Ford / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/6/04 Suitland, Maryland `4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Alexander S. Pope Funeral Homes, P.A. 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASTROINTESTINEAL **Physician** disease or condition resulting in death) /Medical Examiner INSUFFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner death certificate be executed IABETE attending physician end for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 → No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No 1 ☐ Yes 25 N Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funerel I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certifier AUG 2004 Walneson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OXON HILL MO OS/A, OXON HILL ROAD 6192 STE-500 31. Date filed (Month, Day, Year) State AUG 0 4 2004 Registrar

		•	For State Registrar	State of M	laryland		artment <i>rtificate</i>			and M	1ental H	ygien	20	04	250	126
			1. Decedent's Name (First, Middle, Las	st)							2. Date of I	Death		Year	3. Time of	Death
	Physici /Medio		James Donald Far	rall							July 2	21,	2004	1001	1551	M
	Examir		4a. Facility Name (If not institution, give				4b. City, To					4	_	of Death		
			Chester River Ho	-		4 1: - 4 - 4 - 1	Che If Under 1		rtown If Under:		0.0	21.45	Kent			
	uneral		5. Social Security Number 6. Sr 220–40–6353	0 X M 2□F 7.A	ge (In yrs. la 61	Yrs.		Days	Hours	Min.	8. Date of E (Month, I July	Day, Yea I O	r) L943	Cour		r r-oreigi
			Usual Residence of Decedent								July .	LZ, .	1943	ria.	ryland	
ryland	how		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside Cit	-
е Ма	8-8	cto	MD Prince	Georges	В	Bowie						1 Tyes				
ith th	or 20	Die.	10e. Street and Number				10f. Zip C					10g. C	10g. Citizen of What Country?			
ath v	s 23s	ral	12504 Thompson F	Road 12. Was Deceden	Succia III			0720		-i-2 /C-	asitu Vaa as I	la la	US	SA ce - Americ	an Indian	
10 21213-UU30 s filed within 72 hours after death with the Maryland	or result and when the property of thems 23e or 28e-f show them 21e arked other than "naturel", or items 23e or 28e-f show other treumstic event, it is Madical Examiner and be inclified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Tes 2 If Yes, Give Year or Dates:	? (No		f Yes, specifi		Specify:	, Puerto	ecify Yes or f Rican, etc.)	NO-		ck, White,		
2 hot	leal E	Completed	15. Decedent's Ed			16a. Deced	dent's Usual kind of work	Occupat	tion	of work	ina	16b.	Kind of B	usiness/In	dustry	
thin 7	P E E	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use	retired)	uning mosi	OI WOIK	ing					
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Plould bloom	nark	To	19a. Informant's Name/Relationship (7		-	10b Mailin	Address (Stroot a			al Route Num					
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e , -	tem other		20a. Method of Disposition		20b. Pl	ace of Dispo		-			Date			City or To	own, State	
mo Pages	nnt: If it		1 ☐ Burial 2 🛣 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		2	intt Ci				7/25	72004	Wa	ldor	f, MI)	
baltimore,	Importent: if any injury or once.		21. Signature of Funeral Service Licen	see		- 00	Name and	A minima a a	of Facility						1 Home	5
			23a. Part1. Enter the disease, or comp	olications that cause	d the death.										Approximate Interval Betw	9
	/sician ledical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A. Ventricular Fibrillation Due to (or as a consequence of):											Onset and D	eath	
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× ortific	ding p	/Me	IFFEMALE: 23c. If yes, outcome of pregnancy							23d Date of					delivery	
.O. Box 68/ the death certificate	by the attending p tached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic preg Other (spec							te of delivery onth Day Year		ear
J E	deta	by Pt	Part II. Other significant conditions of	ontributing to death	but not resu	Iting in the ur	nderlying cau	ıse giver	n in Part I.		23e. Dio	tobacco	use cont	ribute to th	e cause of de	eath?
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Vital icien:	certificate rector, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only	one)				
OT V	this coal dire	ဥ	1 ☐ Yes 2 X No	Hospital: 1 Inpat		ER/Outpatien			4 🗀 1401		me 5□Re				1)	
	fter	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		Work?			28d. Describe	how inj	ury occurr	red		
ISIC ttend	ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be		niury - At hor	me farm str	M factors		es 2 🗆 N		28f Location	(Street s	nd Numb	er or Rura	I Route Numb	
JOIVISION For Attending		ertification:	4 Homicide determined	building, 6	tc. (Specify))	sol, laciory, i	JIIICO			City or T			or or mara	771001011401110	,
To the Hospitel	To the Funeral Directory of the Completely filled in the	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the bes niner: On the basis and manner s	of examinati	viedge, death ion and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, h occurr	and due to th	e cause(e, date ar	s) and ma	inner as st and due to	ated. the cause(s)	
To the	Toth	Me	29b. Signature and title of certifier				29c. l	License	number			29d. D	ate signe	d (Month, I	Day, Year)	
,- ;	, ,		I pur CUX	M.	W			D16	5197			J	uly	22, 2	2004	
			30. Name and address of person who													
			Andrew C. Lara	9326 Lar			Road	Lan	ham,	MD	20702					
	Sta Regista		31. Date filed (Month, Day, Year) JUL 2 3	2004 32. Re	rar's Signati	-	hand.									
DHWH	17 Rev 1/2		JUL 20	2001		N A	TO THE									

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

AUG 0 5 2004

				State of Maryland				-		egible.			
			1 - For State Registrar			rtificate of		-	Reg. No.	004	25928		
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	ath Day	Year	3. Time of Death		
ļ	/Medi	al	Hazel	Gatewoo	od	I		July 21	1, 200	04	6:35 A M		
	Examir	er	4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of Deat	h		ounty of Death			
-	Funeral		Southern Maryland 5. Social Security Number 6. Se		ast birthday)	If Under 1 Year		8. Date of Bir	th	ince Ge	place (State or Foreign		
	Director		230-62-3609 Usual Residence of Decedent	□M 2X1F 57	Yrs.	Months Days	Hours Min,	(Month, Da	1947	Cou	adelphia,PA		
	Marylan I-f show	tor	MD Prince (, Town or Lo						10d. Inside City Limits 1 X Yes 2 □ No		
	th the	Director	10e. Street and Number	,corge o	OZIII	10f. Zip Code			10g. Citize	n of What Cou	intry?		
	ath wi	rai	9211 Steuart Lane			207				S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show eny injury or other traumatic event, If a Medical Evarrace must be notified at ance.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XNo	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: Black			
Maryland 21215-0036	2 hou eture	Completed by	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/Ir	ndustry		
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7	led wi		12th		Taxi	Cab Drive				ivate			
and	otal H ed otl	Be	17. Father's Name (First, Middle, Last) Unknown					ne <i>(First, Middl</i> e, Woodall					
Ž	should nd Me mark matic	2	19a. Informant's Name/Relationship (7	vpe. Print)	19b Mailir	ng Address (Street	and Number or Ru				Code)		
	and 2 saith ar 127 is ser trau		Barbara Brane/Cous	** * *			Clinton,			Own, State, 24	, 0000		
Baltimore,	Pages 1 ant of He ant of He rt. If item y or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hallioval Holli State		sition (Name of natory or other pla e Cremato	14	Date 27/2004		tion - City or To			
alti	mit. F partme sortar / injur		21. Signature of Furanti Broke Light				ess of Facility JB	1 - 1		-			
Ö	permi Depa Impo eny ii		16				over Rd L	-		20785			
	Physician /Medical Examiner	iner	29a Part1 Enter the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the disease of condition resulting in death) Sequentially list conditions, liany, leading to immediate cause (Disease or injury transport of the disease of the di										
68760,	ificate be executed g physician and as lhe burial-transit	edicai Examiner	resulting in death) Last Due to (or as a consequence of): d.										
.O. Box	The law requires that the death certifica ate has been signed by the attending ph. page 2 should be detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown						23d. Date of delivery Month Day Year				
Δ.	es that igned b	by Ph	Part II. Other significant conditions co	intributing to death but not resu	lting in the ur	nderlying cause giv	ren in Part I.	23e. Did to	bacco use	contribute to the	ne cause of death?		
ä	w require been sig should b	ted	CHRONIC F	ZOTEMIA				1 🗆 Y	es 2□N	No 3 ☐ Prob	pably 4 @Unknown		
Division of Vital Records,	nysician: The law r nis certificate has be i director, page 2 sh	Completed						24a. Was a autop perfor 1 Yes	med?	24b. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available mpletion of cause of 2 No		
Ž	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth		th Check onl or					
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	To the Hospitel or A within 24 hours after To the Funeral Directorpletely filled in by	edical (29a. Certifier (Check only one) 1 Certifying Phy	rsician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the o	ause(s) and pla	d manner as st ace, and due to	ated. the cause(s)		
	To the To the Comp	Ň	29b. Signature and title of certifier			29c. Licens				igned (Month,			
			> Shoul the	m MD		D 5	0862		JULY	21, 2	2004		
((CTS)		30. Name and address of person who c			*							
	Sta	te.	Dr. Satrif Hassan 31. Date filed (Month, Day, Year)	9831 Greenbel 32 Registrar's Signatu		i Lanham,	Marylan	d 20706					
	Registr		JUL 2 9 2004		ander.	20							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .TUT.Y **Physician** COLBERT 2004 7:25 AM **GAYLE** /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE"S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 18 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 60 Yrs. 216-06-4703 Jamica Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits ehow "natural", or Itame 23a or 28a-f ehov olical Examiner must be notified at 1 Yes 2 No Prince George's Lanham Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7221 Sunrise Drive 20706 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Private HouseKeeper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth-any injury or other traumatic event 9DRg: Be Edith Gayle Lurkland Gayle ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7221 Sunrise dr. Lanham Maryland Gayle/Wife Cordelia_ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 7/30/2004 Laurel, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Maryland Narional 22. Name and Address of Facility J. B. Jenkins Funeral Home Signature of Funeral Privice Censes 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA CARDIAC **Physician** /Medical Due to (or as a consequence of) Examiner ANEMIA Sequentially list conditions, Due to (c) as a consequence of) any, reading to antirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed VASCULAK ACCIDENT and burial-tran Due to (or as a consequence of): Box 68760, attending physicien SEIZURE DISORAER Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□ Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 I I Inknown signed by Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. HYPERTENSION 1 Yes 2 No 3 Probably 4 XUnknown Completed HYPER KALEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe ACITIE KENAL FAILURE certificate 1 ☐ Yes 2 X No Division of Vital director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 this in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY PETINAUX 3001 HOSPITAL 31. Date filed (Month, Day, Year)

JUL 2 9 2004 2. Registrar's Signature State Registrar

			FOI	of Maryland / D			ntal Hygien	е	
			State Ragistrar		Certificate of L		Rag. No	. 200	4,250.30
	Physici	an	1. Decedent's Name (First, Middle, Last)	Edna	Greev		Month Da	ay Year 6 2004	3. Time of Death 1 1 130 5 M
	/Medio Examir		4a. Facility Name (If not institution, give street and			Location of Death		c. County of Death	7
	- ZAGITII			spital		Easton		Talbot	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hday) If Under 1 Year Months Days		Date of Birth (Month, Day, Year	9. Birth	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent	Б			1ay 28, 19	17 17010	aryland
	r 28a-f show	_	10a. State 10b. County	10c. City, Town		1			10d. Inside City Limits 1 12 Yes 2 □ No
V	the M	Funeral Director	MD Talbot 10e. Street and Number		10f. Zip Code	reis	10g. C	itizen of What Co	
سنہ	uth with the 23a or 28a ust be not	ig is	610 s. Talbo	- Street	-	1663		USA	
-	ler death	Iner	11. Marital Status 12. Was I	Decedent Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specif In, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
36	urs after death with alt, or Items 23a o	by Fu	If Yes	es 2. ☑No , Give or Dates:	1 ☐ Yes 2 No	Specify:		Specify: 810	ack
een	2 ho	ted	15. Decedent's Education (Specify only highest grade complet	16a.	Decedent's Usual Occupa (Give kind of work done of	ation	16b. l	Kind of Business/I	
een	vithin 7	Completed		ne (1-4or 5+)	life. DO NOT use retired	1)	L C	200 12	Tallective
	be filed within 7. Ital Hygiene. Id other than "n	e Co	17. Father's Name (First, Middle, Last)	1 Y	ocessing	18. Mother's Name (F			+Naustry
P 2		To Be	James Alber	+ Thoma	as	Sophia	a Pin	Kney	
Rawland		1	19a. Informant's Name/Relationship (Type, Print)	1 2 3	Mailing Address (Street a				"ip Code)
	C, IV 1 and Health 6m 27		James Gree	20b. Place of	OSTAIL Disposition (Name of y, crematory or other place)	ot Stree	T 37/V	Location - City or	S. MD. 21663 Jown, State
ع يُ	Pages nent of I int: If it		1 Burial 2 □ Cremation 3 □ Removal fi 4 □ Donation 5 □ Other (Specify)	om state	s, crematory or other places	$I \cup OIAI$	04 St	Michae	IS MD.
Grac	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to		21. Signature of Funeral Service Licensee	1/ G	22. Name and Address	ss of Facility	tome P.A	١,	,
ο α	Per Per Bury Bury Bury Bury Bury Bury Bury Bur		Janelle C. S	Henry	510 Was	hinaten S	t, Cambr	idge, MI	0,21613
			23a. Parts Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	not enter the mode of dyin	g, such as cardiac or re	espiratory arrest,	,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	ve ell -	on:				Days
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The	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (> s a consequence o	of):				
•	te be executed ysician and e burial-transit	Exan	that initiated events c	to (or as a consequence of	of):				
052	2 > 9	cai	d						
ď	BUX OG Bath certifica attending ph for use as th	Physician/Med	IF FEMALE: 23c If yes	, outcome of pregnancy		2.00		00d Date of date	
Ġ	eath c attend	cian	23b. Was decedent pregnant	ive birth 2 Fetal death regnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli Month	Day Year
	that the death	hysi	9 Unknown 9 U	nknown					
9	n 8 5 6	by	Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause give	en in Part I.		use contribute to	o the cause of death?
3	w require	Completed					24a. Was an	24b. Were au	itopsy findings available
Č	ner The lav	omp					autopsy performed? 1 ☐ Yes 2 ☐ N	prior to death?	completion of cause of
	ysician: The l ysician: The l is certificate ha director, page	BeC	25. Was case referred to medical examiner?			26. Place of Death (C			-
2	Physic this ce al dire	2	1 Tyes 2 No Hospital:	Inpatient 2 ER/Ou		4 Nursing Home	5 Residence		aify)
2	ding th.	tion	1 Natural 5 Pending 2 Accident investigation		njury Worl	k? Yes 2 □ No	2. 20301100 11011 1111	ary occurred	
	r Atter er dea rector	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. F	Place of Injury - At home, fa	ırm, street, factory, office	28f	. Location (Street a City or Town, Sta		ıral Route Number,
Ö	pital or ours aft eral Di				dooth account at the tie	no idata and alama	A due to the govern	(a) and manner on	atatad
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medical	29a. Certifier (Check only one) Certifying Physician: To the discal Examiner: On the and						
	To th within To th comp	Me	29b. Signature and title of certifier	- H 0 00	29c. Licens	e number		ate signed (Month	,
			Dasshim Varaya	regnen IV	9 10	5 //	+7 JUL	7 26	2004
			30. Name and address of person who completed Lakshmi Vaidyanathan,		1 1	St., Easton	, MD 2160	01	
		ate		32. fegistrar's Signature			, === 2200		
	Regist	trar	JUL # 9 5004	William St.	March				

			1 - For State Registrar		State of	Marylar		artmen rtificate				lental Hy	Reg. No.	00i;	259	31
	Physici	an	Decedent's Name (First, Michael Control of the	ldle, Last)								2. Date of De Month	Day	Year	3. Time of	
	/Media			Mae		Grove						July	31	2004	6:50	A ^M
	Examir	er	4a. Facility Name (If not institut			ber)		1		Location of			4c. C	ounty of Death		
			Beverly Heal 5. Social Security Number	6. Sex		'. Age (In yrs.	last birthday)	If Under		erick H Under		8. Date of Bi	rth	Freder	LCK place (State or	r Foreign
	Funeral Director		218-24-7590 Usual Residence of Decedent		2 X F	88	Yrs.	Months	Days	Hours	Min.	Aug. 6	ay, Year)	5 Mar	yland	- Toreign
	yland yow		10a. State 10b. Cour	ty		10c. Ci	ty, Town or Lo	cation							10d. Inside Cit	y Limits
	Man a-f sh	tor	Maryland Fred	erick			Frede	rick							1 🔀 Yes	2 🗌 No
	or 28,	ire	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What Cou	ntry?	
	23a	Funeral Director	30 North Pla	ce					217	01			Uı	nited S	tates	
	er deg	nue	11. Marital Status		Armed Ford		I.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexican	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	0- 14	 Race - Ameri Black, White 		
36	or t	by Fi	1 X Never Married 2 M 3 Widowed 4 Divorce		1 ☐ Yes 2 If Yes, Give Year or Dat			1 ☐ Yes	2⊠ No	Specify:			S	pecify: Wh	nite	
8	t hour	ed k		ent's Educat		165.	16a. Dece	dent's Usua	al Occupa	ition			16b Kind	of Business/Ir	dustry	
7	n 72	plet	(Specify only high	nest grade c		4or 5 v)	(Give	kind of wor DO NOT us	rk done d se retired,	uring mosi	t of work	ing		01 200,1000.1		
2	d with giene er the	Completed	12	,	College (1-		Sa	les C	lerk				Ant	ique St	ore	
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "neturel", or Items 23a or 28a-f show attc event, I're Medical Exartiner must be rediffed at	Be (17. Father's Name (First, Midd									(First, Middle		umame)		
Хa	ould to Ment arke	^o	Cleveland Th									dell Y		· · · · · ·		
<u>a</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be notified at Once.	0.1	19a. Informant's Name/Relation					_				d Route Numb			′	
	1 and Health em 27 ther t		Mia Burst / So	cial v	vorker		1440	•			-	lerick,		tion - City or T		
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Ba	Depar Impo any ir		N/V	1) -												
87	Pnysician /Medical											Approximate Interval Betw Onset and D Years	veen eath			
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		ophren	ia wit	h Par	anoi	a					Years	3
3760,	ate be executed obligation and the burial-transit	dical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bid quence of):								Years	3			
P.O. Box 687	t the death certific by the attending p ached for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 No 2 No 2 No 2 No 2 No 2 No 2 N									000	эпг		
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CO	w requires to the second secon	lete	Osteoarthitis	. Fai	lure t	o Thri	ve					24a. Was	an	24b. Were auto	posv findings a	vailable
al Re		Completed										auto perfo 1 Yes	ormed?	death?	mpletion of car 2🛛 No	use of
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o	Phys or this oral di); To	27. Manner of Death		28a. Date of (Month		ER/Outpatier 28b. Time of		8c. Injury Work	4 23 140	_	me 5 ☐ Resi 28d. Describe			(y)	
lon	th. : After e funer	atlor	1 XNatural 5 ☐ Pen 2 ☐ Accident inve	ding stigation	(Month	, Day Year)	Injury	м		? ′es 2 🗆 !	No					
Division of Vital Records,	by Se	Certification;	3 ☐ Suicide 6 ☐ Cou	Id not be rmined		of Injury - At h g, etc. <i>(Specii</i>	ome, farm, str fy)	eet, factory	, office			28f. Location (City or To		lumber or Rura	al Route Numb	ΘΓ,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 X Certification (Check only one) 2 Medic	ying Physici al Examiner	an: To the bas On the bas and manne	sis of examina	owledge, death	occurred vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and pl	d manner as s ace, and due to	tated. the cause(s)	
	To the H within 24 To the Fi complete	Me	29b. Signature and title of cert	fier	/)-	111		290	. License	number			29d. Date s	igned (Month,	Day, Year)	
			Melles	1/	Cec	ll	1 h	11)	D547	49			Ju1y	31, 2	004	
	2		30. Name and address of personal Allen Reilly				n 3a) (Туре, louse A	,	Fr	ederi	ck.	Maryla				
	Sta	- 0.0	31. Date filed (Month, Day, Ya	v)		gistrar's Signa		/			-					-
	Registr	ar	00	- V U Z	.UU4 P	Dener	1	19								

			1- State of Maryland / Dep Registrer Co	partment of Health and Nertificate of Death		ene . No 2004	25932						
	Physici /Medic		Decedent's Name (First, Middle, Last) Warren Louis Groomes		2. Date of Death Month August 2	Day Year , 2004	3. Time of Death 5:15 a M						
	Examin		4a. Facility Name (If not institution, give street and number) 6134 Montrose Road	4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's							
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Oct. 11,	Birth Day, Year) 11, 1912 9. Birthplace (State or Foreign Country) Maryland							
	he Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Maryland Prince George's Che 10e. Street and Number	Location verly	100	. Citizen of What Cour	10d. Inside City Limits 1 X Yes 2 □ No						
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itams 23e or 28a-f show early injury or other traumatic avant, its Modical Examinate in all the modified at once.	by Funeral Director	6134 Montrose Road 11. Marital Status 1 □ Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes Size	20785 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		U.S.A. 14. Race - Americ Black, White,	can Indian, etc.						
Maryland 21215-0036	within 72 hours ane. than "natural", r Mudical EX.	Completed by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	eedent's Usual Occupation re kind of work done during most of work DO NOT use retired) 1road Engineer	ing	Whi b. Kind of Business/In ushington Te	WNITE d of Business/Industry						
land 2	uld be fited v Aental Hygie rked other i tic avant, II	To Be Co	17. Father's Name (First, Middle, Last) Clarence Groomes		e (First, Middle, Mai	iden Sumame)							
	and 2 sho ealth and A n 27 la ma ier trauma		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	iling Address <i>(Street and Number or Rui</i> 4 Montrose Road , C			Code)						
Baltimore,	Pages 1 a nent of Hez int: If itam iry or othe		1 X Burial 2 Cremation 3 Removal from State	position (Name of ematory or other place) n National Cemetery 08,		c. Location - City or To							
Balt	permit. Page Department of Important: If eny injury or once.		1.	^{22. Name and Address of Facility} Ga 4739 Baltimore Ave		eral Home, ville, MD							
	Pnysician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
8760,	Examiner Nysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
.O. Box 6	that the death certifics ned by the attending ph detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5 9 □ Unknown		23d. Date of delivery Month Day Year								
Q	w requires that been signed b should be deta	by	Part II. Other significent conditions contributing to death but not resulting in the Cerebral Infarction	underlying cause given in Part I.		cco use contribute to the							
II Reco	The law requate has been page 2 shout	Completed	Arteriosclerotic Cardiovascular Dis	ease	24a. Was an autopsy performed	prior to condeath?	psy findings available mpletion of cause of						
Vita	Icien: sertific ector,	Be	25. Was case referred to medical examiner?		h (Check only one)								
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To	1 Yes 2 No	of 28c. Injury at	me 5 ሺ Residenci 28d. Describe how i		y)						
Divis	al or Atta s after dec al Diracto ed in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	n (Street and Number or Rural Route Number, Town, State)							
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de- 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as si and place, and due to	ated. o the cause(s)						
,	To t To t	Σ	29b. Signature and title of certifier	29c. License number D01852		Date signed (Month, August 2,							
th.	12		30. Name and address of person who completed cause of death (Item 23a) (Type Paul A. DeVore, M.D., 4203 Queensburg		e, MD 207	781							
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 3 2004	K)									

Joel Gildersleve 04-04857 MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

100	,		For State Registrar	State of M	larylan	•	artment of H		Mental Hy	giene	nL	25933
	Physici	an	Decedent's Name (First, Middle, Last JOEL	GILDER	CI EVE				2. Date of De Month	26, Day 200	∆ Year	3. Time of Death 2110 P M
	/Medic Examin		4a. Facility Name (If not institution, give 1800 Block Churc	street and number			4b. City, Town, or Bowie	Location of Death		4c. Count	y of Death	George's
	Funeral Director		5. Social Security Number 6. S 218-31-6414	9x 7. A	ge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Do March	rth ay, Year) 14 1991	9. Birthr Cour Mar	place (State or Foreign ntry) y Land
	aryland show	٥٢	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo					1	10d. Inside City Limits 1 ☑ Yes 2 □ No
	n the N	irect	MD Prince (eorge's		Upper	Marlboro 10f. Zip Code			10g. Citizen of	What Cour	
	23a c	aiD	106 College St	ation Dr	ive		207	74		U.S.A		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. The stransked other than "natural", or items 23a or 28a-1 show other traumatic evant, Its Madical Exactings cast by notified at	by Funeral Director	11. Marital Status 1 ★ Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Deceden Armed Forces 1 Tes 2 Tes 11 Yes 2 Tes Yes, Give Year or Dates	? No	1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		ce - Americ ck, White, fy: B	
21215-0036	in 72 ho n "natur Asolical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	- \	16a. Deced (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of world	king	16b. Kind of B	usiness/In	dustry
212	ed with giene er tha	Com	Elementary/Secondary (0-12) 8th	College (1-4o	5+)	None				None		
Maryland	be fife ital Hy od oth	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam		e, Maiden Sumar	ne)	
ry la	thould id Mer marke matic	٦	Joseph Gildersle 19a, Informant's Name/Relationship			19b. Mailir	og Address /Street	Beatric		per City or Town	State Zir	^{Code)} 20774
Ma	is 1 and 2 s of Health an itam 27 is other trau		Beatrice Gildersl		er		college St					
altimore,	les 1 a of Her of Her if itam		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	1 ^	Place of Dispo emetery, crer	sition (Name of matory or other place	e)	Date	20c. Location	- City or To	own, State
tim	t. Pag rtment rtant: njury o		* 4 □ Donation 5 □ Other (Specify	()	Gat		leaven Cer	4 = 10.				ng,Maryland
Ba	Department of He Important: If itan any injury or oth once.		21. Signature of Funeral Service Licer	shall	/		Name and Addres 7474 Land	J		enkins F ver, Mar		
			23a. Part1. Enter the disease or com shock, or heart failure. List only	plications that cause one cause on each	ed the death line.	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory a	arrest,	6	Approximate Interval Between Onset and Death
	Inysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	amuld Due to (or a	s a conseq	uenke f):	ies					Onset and Death
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	ecuted and transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C								
8760,	cate be executed physician and the burial-transit	dicai E	rosuming in dodain, Educ	Due to (or a	s a conseq	uence or):						
	that the death certificated by the attending placed for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	I death 3	Ectopic pregnancy Other (specify)				ite of delive	ery Day Year
ds, P	ires that signed b d be deta	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying cause give	en in Part I.		tobacco use con		ne cause of death?
Records,	The law requires are has been sign bage 2 should be	ietec							24a. Was	1		psy findings available
_	10	Completed							auto perfo 1 Yes	psy ormed? 2 \(\text{No} \)	prior to cor death?	mpletion of cause of 2□ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	26. Place of Dea				
o	Phys rthis ral dii	To it	1 X Yes 2 No 27. Manner of Death	28a. Date of In	jury	ER/Outpatien 28b. Time of	28c. Injury	at Nursing H	ome 5 Resi	how injury occur	red	y) At scene
ion		atior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 120	ay Year)	S:5	PM 1□	Yes 2 No	brase us	ec in mo	cide	refrice
=	o ira	Certification:	3 Suicide 6 Could not b 4 Homicide determined	200. Flace of I	njury - At ho etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and Numb yen, State)		Negate Nymber,
	To the Hospitel or At within 24 hours after of To the Funarel Diract completely filled in by	ledical (29a. Certifier 1 ☐ Cartifying Ph (Check only one) 2 ☑ Medical Exam	ysician: To the bes	of examina	wledge, death tion and/or in	n occurred at the time vestigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and madate and place,	anner as st	ated. the cause(s)
,	To th within To th compl	Me	29b. Signatore and title of certifier	nia-Pa	300	Icnie	29c. License O.C	.M.E.		29d. Date signe July		*
((3)		30. Name and address of person who	completed cause of	11 11	23a) (Type,	Print) 111 Pen	n Street	, Baltir	more, Ma	rylar	nd 21201
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 3 2004	32. Regis	trar's Signa	ture	',					
DHN	MH 17 Rev 1/2	001				7						

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 14 25934
ı	Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year OH OH OH OH OH OH OH OH OH OH OH OH OH
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Ame Arundel Medical Center Amapolis, MD 4b. City, Town, or Location of Death Ame Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington, DC
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryl	tor	Maryland Prince George's Cottage City 1\(\frac{\text{Y}}{2}\) os 2□No
	or 288	Jirec	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	s 23a	rail	4142 Bunker Hill Road, Apt. 405 20722 U.S.A.
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-1 show myn injury or other traumatic event, the Medical Evairiest institled at ance.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or Nollif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Race - American Indian, Black, White, etc. 17. Yes, Sive YWII 19. Yes 2 No Specify: White
2-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry
Maryland 21215-0036	filed within Hygiene. Ither than "	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 (Give kind of work done during most of working life. DO NOT use retired) Entrepreneur Private
d 2	2 should be filed withir and Mental Hygiene. Is marked other than aumatic evant, Liu Ms	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
ylar	should be to and Mental I is marked of umatic eva	ToE	Joseph John Gauzza Mary Susan Day
Mar	d 2 sh th and th and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Yetter - Daughter 467 Walnut Drive, Edgewater, MD 21037
	as 1 and 2 of Health litem 27 I		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	Pages ment of h ant; If ite lury or of		*4 Donation & Other (Specify) Fort Lincoln Cemetery 08/03/2004 Brentwood, Maryland
Balt	permit. Pag Department: Important: I any injury o		21. Signature of Funeral S. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781
ı			23a. Párt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):
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	pet lad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
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8760,	cate be executed oblysician and the burial-transit	licai	d
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ecords, P.	quires that the signed by ald be detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
eco	law require as been si 2 should b	Completed	24a. Was an autopsy prior to completion of cause of
α	10 LT	Com	performed? death? 1 Yes 2 No 1 Yes 2 No
Vital	Physician: this certificanal director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2 No Check only one 1 Yes 2
o	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
sior	Attanding r death. ector: After oy the fune	catic	2 Accident investigation M 1 Yes 2 No
Division	al or Attand s after death il Director: od in by the	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai (23a. Cert ier (Check Guily one) Check Guily and manner as stated. Check Guily one) Check Guily and manner as stated. Check Guily one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the comp	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	00		A. Chopra D57028 7/29/04
0	70		30. Name and actives of person who completed cause of death (Item 23a) (Type, Print) A DITYA CHOPRA 400 Rickly Ave. Suite 231 31. Date filed (Month, Day, Year) AUG 0 3 2004 AVINCIPOUS, MD 21401
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 3 2004 AVINCIPOUS, MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Gallozzi 07 26 4:25 Α 2004 Edith Bernice_ /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WILLIAM HILL MANOR EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 7 1909 9. Birthplece (State or Foreign Country)
PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🙀 F 95 Director 199-28-9468 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits "naturel", or items 23s or 28s-f show Examiner count by notified at 1XXYes 2 ☐ No Director EASTON TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 USA Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: þ 3 ♥ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) than FEDERAL GOVERNMENT MUSIC DEPT. LIBRARIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JESSE H. BARLOW ALMA THOMPSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is W. THOMAS FOUNTAIN/PER REP. 16 S. WASHINGTON ST EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 7-28-2004 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 'n 至. MERCEROF CHO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Tu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed Referestive Due to for as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D08715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 DUTCHMANS LANE EASTON, MD 21601 WILLIAM H. WOOD JR. M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

			For State Registrar	State o	of Marylan	•	artment of H rtificate of I		and Ment		iene	25936
	Physicia	an	Decedent's Name (First, Middle,						a.M	ate of Deat	Day Yea	
	/Medic Examin		Thomas Joseph G		mber)		4b. City, Town, or	Location of		gus t	4c. County of D	
	LXamin		Washington Coun	ty Hospit	:al		Hagersto				Washingt	on
H	Funeral Director		285-26-1879	6. Sex 1 <u>M</u> M 2 ☐ F	7. Age (In yrs. 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (M	ate of Birth fon <i>th</i> , Day,	Year)	Birthplace (State or Foreign Country) LO
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	a-f sh	tor	Maryland Washin	gton	Hage	rstown	l					1 X Yes 2 □ No
	or 28	Funeral Directo	10e. Street and Number				10f. Zip Code				0g. Citizen of What	Country?
	eath v	eral	13220 Greencast		edent Ever in U	.S. 13. V	21740 Was Decedent of H	ispanic Ori	gin? (Specify Y		14. Race - A	merican Indian,
و	after d or Itan nimer	Fun	1 ☐ Never Married ZX Marrie	Armed F			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🕱 No		i, Puèrto Rican	, etc.)	Black, W	hite, etc.
9	ural',	d by	3 Widowed 4 Divorced	Year or I	Dates: 1936-	-56					Specify: W	
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tlams 23s or 28s-f show that the Medical Evand without be notified at	Completed	15. Decedent (Specify only highest	grade completed,	-	(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	t of working		16b. Kind of Busine	ss/Industry
212	filed within Hygiene.	Com	Elementary/Secondary (0-12)	2	1-4or 5+)	Techr	nical Wri	ter			Aircraft	Manufacturing
Maryland 21215-0036	ed ita	Be	17. Father's Name (First, Middle, L						,		Maiden Sumame)	
3	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. In marked other than "natural", or Itams 23s or 28s-1 show marked other than "natural", or Itams 23s or 28s-1 show matic event, The Medical Evair act must be notified at	은	Sebastian Gar	gano		19b. Mailir	ng Address (Street		Esposi		, City or Town, State	a, Zip Code)
	d 2 in a in a in a in a in a in a in a in		Mildred Gargana									land 21740
Baltimore,	of Head of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		State 20b. F	Place of Disponentery, crer	esition (Name of matory or other place	e)	Date		20c. Location - City	or Town, State
Ē	t. Pag rtment rtant: njury o		`4 Donation 5 □ Other (Sp	ecity)			en Cemete		8/4/200			n, Maryland
Ba	permit. Pages 1 an Department of Heal important: If item 2 any injury or other once.		21. Signature of Funeral Service L	Lensee .	~						Funeral (_
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on	caused the deat each line. PER KA			g, such as	cardiac or resp	iratory arro	est,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to	(or as a conseq		ENAL D	IS EAS	SF			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	-	(10110 0	(5 ((-		_		
	cate be executed oblysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conseq	mence of):						
8760,	sicien burial	al E			(01 43 4 0011304	udi 100 01/.						
9	tificate ig phys as the	ledic		d								
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 Feta nant at time of c nown	ldeath 3[Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year
	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditio	ns contributing to		ulting in the u	nderlying cause giv	en in Part I	. 2	3e. Did tol	pacco use contribute	to the cause of death?
ord	w require been si should l	ted	CONGESTIVE H	E1184 F	ALLURE					-		Probably 4 Unknown
Division of Vital Records,	The law cate has by page 2 si	Completed	PNEUMONIA.							4a. Was a autops perforr	y prior	autopsy findings available to completion of cause of 1? 'es 2 No
Vita	Phyaician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	Secretary OF	ER/Outpatier	Oth	er.	of Death (Che			· * · ·
on of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	I	27. Many r of Death 1 Natural 5 Pending 2 Accident investig			28b. Time o Injury	f 28c. Injur Wor	y at	28d. D		ence 6 Other (Sow injury occurred	респу)
Divisi	or Atter after dea Director d in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 280. Fide	e of Injury - At h ding, etc. (Speci	ome, farm, sti	reet, factory, office			ocation (St lity or Town		Rural Route Number,
	To the Hospital or Attending, within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C		xaminer: On the							ause(s) and manner ate and place, and o	
		Me	29b. Signature and fittle of certifier	-			29c. Licens		_ /		9d. Date signed (Mo	
)	12-10x1							590.	5.5		Hugust	4, 2007
ن	it,		30. Name an lad ress of person	who completed car	use of death (Item	m 23a) (Type,	Je Hill	And	H	4	August	742
	Sta Regist		31. Date filed (Month ADGY 4)	2 2004 32.	Registrar's Sign	ature	berke	*+4**		1		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7-17-2004 Year **Physician** Donald Shaeffer Gross 7:25P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Genesis Elder Care Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 30/ Pennsylvania Director 1924 225-28-6139 80 Usual Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d Inside City Limits 28a-f show itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Mcdical Examinar must be notified at XXYes 2□No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 2608 Point Lookout Cove Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 72 hours after Xes 2 No WWII 1 Never Married 2 Married 1 ☐ Yes 2 ᡚNo Baltimore, Maryland 21215-0036 ⋧ Specify: White 3. Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If itam 27 is marked other th. any injury or other traumatic event, the once. Engineer Univ. of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shaeffer Frances Rufus Stewart Gross ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Buppert/Daughter 21 Decatur Ave. Annapolis, MD. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2√7 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Edgewater, MD. Kalas Crematory 7/20/04 21. Signature of Funeral Service License 22. Name and Address of FacilityGeo.Kalas Funeral Home 40 12973 Solomons Island Rd. Edgewater, Md. 2103 ap . Enter the disea e, or com ck, or heart failure. List only Approximate Interval Between Onset and Death comp, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only the cause on each line. Sub dural Luature Immediate Cause (Final disease or condition Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ed bluods 3 ☐ Probably 4 ☐ Unknown 1 Tes 27 No Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2/27No 2□ No 1 Yes 1 TYes or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Patural 5 Pending investigation death. М 1 □ Yes 2 □ No 2 Accident the 1 within 24 hours after deatl To the Funaral Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide *Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely ha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 32636 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) >04 31. Date filed (Month, Day, Year) State 1 2004

DHMH 17 Rev 1/2001

Registrar

Registrar

AUG 05

2004

Amend Item 27 State of Maryland / Department of Health and Mental Hygiene per Dr., G834,08/13/04dhb.

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death July 14, **Physician** 2004 James Grierson 1:47 PM · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel 6. Sex 1 **X**M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 218-10-7869 Director 84 Oct.9, 1919 Maryland Usual Residence of Deceden permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, "In Medical Examinar mast be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Brooklyn Park Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 W. 10th Avenue 21225 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943-13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1945 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 🖫 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Frederick Grierson Estella Se1bv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Coolahan / Niece 611 Holy Cross Road, Brooklyn Park, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20c. Location - City or Town, State 7/20/04 Baltimore, Maryland 4 ☐ Donation 5 ② Other (Specify) Bayview Crematory 21. Signature of Fundral Servin Licensee 22. Name and Address of Facility Harman Funeral Service, P.A. M01113 7221 Grayburn Drive, St. G. Glen Burnie, MD 21061 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t failure. List only one cause on each line. Approximate Onset and Death **Physician** CEREBROVASCULAR ACCIDENT Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 - Yes 2 Ktic 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 Lacurage of was 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 710 CHURCH ST. BALTIMONE, MD 21228 S. DHARMASENA, MED. 32. Registrar's Signature Registrar

					State o	r Maryla	•	artment of F rtificate of	iealth and r <i>Death</i>		giene Reg. No.?	01.	2501.0
			1. Decedent's Name (F	irst, Middle,	Last)					2. Dete of Dea	ath		3. Time of Death
	Physici		Monda Adal	TT	- 6.6					Month August	Day	Year 004	10.FF D4
A. C. L.	, /Medi ∰rExamir		Marie Adel 4a Fedility Name (If no	institution,	PITNEY give street and nur	nber)			4b. City, Town, or L				10:55 PM
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	Funeral		Julia Man 5. Social Security Num	or Hea	alth Care	7. Age (In yr.	s. lest birthdey)			8. Date of Birt (Month, Da)			ce (State or Foreign
н	Director		261-22-752	0	1□M 20XF		85 Yrs.	Months Days	Hours Min.		v. Year) 1918		
			Usuel Residence of De							WL. S.	_1510	Maryl	and
	ylan		10a. State 10	0b. County		10c. C	city, Town or Lo	cation				100	I. Inside City Limits
	Mar	ģ	Maryland	Washir	naton	TH	agersto	NATO				i	1 Yes 2 No
	r 28	Director	10e. Street and Numbe			,	agerbee	10f. Zip Code			10g. Citizen of	What Country	/?
	h wit	2	11403 Sto	no Cre	oft Count			217	40				
	deat	Funeral	11. Marital Status	ne cre	12. Was Dece	dent Ever in	U,S. 13. \	217 Was Decedent of F	4Z lispanic Origin? (Si an, Mexican, Puerto	pecify Yes or No-	14. Ha	ce - American	Indian,
0	after or the second		1 Never Married		Armed Fo	rces./ 2⊠No				o Hican, etc.)	Dia	CK, WITHO, OIL	.
05	er, c	by	3 Midowed 4 □	Divorced	If Yes, Giv Year or D	e ates:		I□Yes 2XINo	Specify:		Specif	v: Whit	е
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28e-f show thit, the Medical Examiner must be notitied at	Completed by	15.	. Decedent's	Education grade completed)		16a. Deced	lent's Usuel Occup	pation	kina	16b. Kind of B	usiness/Indu	stry
21	within ene.	g	Elementary/Seconda		College (1	-4or 5+)	life.	OO NOT use retire	during most of word d)	Ni ig			
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nd	be filed withintel Hygiene. d other then event, the M	Be	17. Father's Neme (First	st, Middle, L	ast)				18. Mother's Nam	ne (First, Middle,			
<u> a</u>	should be filed withind Mentel Hygiene. I marked other than umatic event, the M	P	Farl Rager						Fdna	Rebecca	Martin		
Baltimore, Maryland	d 2 should th end Men 7 is merke treumetic		19a. Informant's Name	/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town	State, Zip C	ode)
Σ	CENL		Jane R. Gr	ove /	Daughter		8414	Tusings	Way Boons	boro. Ma	arvland	21713	1
<u>e</u>	S = 5		20a. Method of Disposi	ition	_	20b.	Place of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Location		ı, State
Ē	W O _ E		14⊡ Burial 2 □ C 4 □ Donation 5 [3 □Removal from : ecify)			urch Cem		8-4-04	Boonsb	oro. M	arvland
Ħ	permit. Peg Department Important: i any Injury o		21. Signatur of Punera						ss of Facility Do				
B	Dep Imp any		1/ /	- 1	Ha. Ch	- 2	13	21 Factor	m Plyd	M Hagon	cetorm.	Maryl	and 21742
			23a. Part1. Enter the d	nus	Tuasa	1	11						
-C.	3.		shock, or heart fa	ailure. List o	nly one cause on e	ech line.		1				i In	pproximate Iterval Between Inset and Death
	hysician /Medical		Immediate Cause (Fina	al		١ ,	`	obeta	etite.	Lung	Disca		noot and boat.
	Examiner		disease or condition resulting in death)	α.	a	1401	110	0 13 60			91		
		- a				Due to	(or as a conseq	uence of):				1	
	ted nsit	Examiner			b								
	ificete be executed g physician end es the burlel-trensit	Xal	Sequentially list conditi if any, leading to imme cause. Enter Underlyin Cause (Disease or inju	ions, idiate		Due to	(or as e conseq	uence of):				1	
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287	ificete g physes the	edical	resulting in death) Last	8		Due to	or as a conseq	uence of):				1	
	ding se e				d								
Вох	eath certifi attending (I for use es	Clar											
o	the dr	Physician/M	Part II. Other significar	nt condition	s contributing to de	ath but not re	sulting in the ur	nderlying cause giv	en in Part I.	23b. Did to	obacco use co	ntribute to th	ne cause of death?
P.0	that the by determined									1 🗆 ነ	res 2□ No	3 Probat	oly 4 Unknown
of Vital Records,	The law requires that the death cert sie hes been signed by the attendin, page 2 should be deteched for use	db								04- 144-	no outces:	24h Mor-	autopsy findings
0	been shoul	ete								24a. Was a perfor	med?	availa	ible prior to
<u>e</u>	e law hes t	Completed					_					of dea	
=		S								144	es 21/011/u	1□Y	'es 2□ No
/ita	Physician: The this certificete rel director, pag	Be	25. Was case referred examiner?	to medical					26. Place of Deat	th (Check only or	ne)		
=	sir sir	2	1 Yes 2 No		Hospital: 1 □ I	npatient 2[☐ ER/Outpatien		41 Trursing Ho	ome 5 Resid	ence 6 Doth	er (Specify)	
П	ng Ph fter th merei	Ë	27. Manner of Death 1. Natural 5	. □ Pending	28a. Date of (Mont	of Injury h, Dey Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe h	ow injury occur	red	
Sio	Attending or death.	cati	2 Accident	investiga				M 1	Yes 2□No			4	
Division	il or Attending Pi efter death. Director: After ti d in by the funere	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	G Could no determin	ed 286. Place	of Injury - At I	home, farm, stre	et, factory, office		28f. Location (S City or Tow		er or Rural R	oute Number,
	tal or is efte al Dire			,									
	To the Hospital of within 24 hours error to the Funeral D completely filled in	Icai	29a. Certifier (Check only 2	Certifying Medical E	Physician: To the kaminer: On the ba	best of my kn	owledge, death	occurred at the tir	ne, date and place,	and due to the o	ause(s) and ma	anner as state	e cause(s)
	the F	Medicai	One)		and manr	er stated.							
	S S S S S S S S S S S S S S S S S S S	2	29b. Signature and title	ot certifier	M-1			29c. Licens			29d. Date signe	d (Month, Da,	y, Year)
			- fen	M	V - 5000-20	\			06039	1	212	154	
			30. Neme and eddress	_	ho completed caus	e of death (Ite	m 23a) (Type,	Print)	c 1/	.00 =	. 0117		
	taen - on		FARI	D	MUM	SHC	1) 115	O OPITLY	CT HAG	MID 21	740		
	Sta		31. Date filed (Month, L		32. R	gistrar's Sign	nature	1 .					
	Registr	ar	A	UG U	3 2004	Meer	B. 16	perle					

DHMH 16 Rev 6/95

Physic	ian	Decedent's Name (First, Middle,	er fh,gc,8/6/04	Certificate of		2. Date of De		3. Time of Dea
/Medi	cal	RUTH	HENSON			JULY	24 20	004 12:54 P
Exami	ner	4a. Fecility Name (If not institution, 4870 66th Ave.)			or Location of Death		4c. County	
Funeral			6. Sex 7. Age (In yrs. last b		r Hills			e George's
Director		217-10-8109 Usual Residence of Decedent	1□ M 2 © F 91	Yrs. Months Days		8. Date of Bird (Month, Da June 1	y, Year)	9. Birthplace (State or For Country) Maryland
jene. r than "naturel", or iteme 23s or 28s-f show the Medical Extendiner must be notified at	ector			wn or Location	.ls			10d. Inside City Lin
3a or	I Dir	10e. Street and Number 4870 66th Aven:	116	10f. Zip Code	20705		10g. Citizen of	
Erian	nere	11. Marital Status	12. Was Decedent Ever in U.S.		20785 Hispanic Origin? (Spe	acity Vas or No.		S.A.
rel', or ite Examine	d by Funeral Director	1 Never Married 2 Marrie 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cul		Rican, etc.)	Blac	ck, White, etc.
ne. han "natu e Madical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of worki	ing	16b. Kind of Br	usiness/Industry
other t		7 th	and the same of th	Line Work			Priv	ate
0 0	o Be	Albanus Washin	,		18. Mother's Name			10)
Item 27 is marke other traumatic	P	19a. Informant's Name/Relationship	n (Type Print)	o. Mailing Address (Street	Gertrude		_	
27 la		Alva Hooper/Bay	ster	905 Pin Oak				
I Item		20a. Method of Disposition	20b. Place of	f Disposition (Name of	D	ate A		20721 City or Town, State
partment of portion of injury or of 28.		1	waugh	Cemetery 22. Name and Address	7–29-		Cambridg	ge, MD
eny ii		K. D. Hars	hall			B. Jer Landove	ikins fu r. Marv	neral Home land 20785
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the death. Do	not enter the mode of dyi	ng, such as cardiac o	r respiratory arr	est,	Approximate
sician		Immediate Cause (Final disease or condition	Stroke					Interval Between Onset and Death
ledical iminer		resulting in death)	Due to (or as a consequence	of):				
	_	Sequentially list conditions.	b. Atheroscleroti		cular Dise	ase		
n and al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
g physicien and as the burial-transit	cal		d					
by the attending phy tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnanc; 5 □ Other (specify) _	y		23d. Date Mon	e of delivery hth Day Year
igned b	by Pf	Part II. Other significent conditions	s contributing to death but not resulting in	the underlying cause giv	ren in Part I.	23e Did toh	Dacco use contri	bute to the cause of death?
plnod								3 Probably 4 Dunknow
rector, page 2 s	e Completed	25. Was case referred to medical				24a. Was autops perform 1 Yes 2	y pr ned? de	/ere autopsy findings availab rior to completion of cause of eath? □ Yes 2₽ No
s cert	To B	examiner?	Hospital:	tratient 3 DOA Oth	26. Place of Death			
		27. Manner of Death	1 Inpatient 2 ER/Ou 28a. Date of Injury 28b. T	Patient S_ DOA	4 Nursing Hom		nce 6 Othe	
Diractor: After I in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	ion be 28e. Place of Injury - At home fa	njury Worl	Yes 2 □ No			r or Rural Route Number,
filled in			building, etc. (Specify)			City or I own	, State)	
To the Funeral D completely filled in	ledic		Physician: To the best of my knowledge aminer: On the basis of examination and and manner stated.	201 IIIVOSIIGAION, III IIIY O	pirion, death occurred	d due to the ca	use(s) and man ite and place, ar	ner as stated, nd due to the cause(s)
F 8		De la control de	1	29c. License	226 (29		(Month, Day, Year) -04

			1 For State		aryland / Depa	artment of	Health and	•	iene		00010
			Registrer		Ce	rtificate of	Death	Re	eg. NG. U U]4_	25942
	Physic	ian	Decedent's Name (First, Middle, Land)	·				2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medi	cal	ManGane	+ 416	BIE			0+		4008	21:32 M
	Examir	ner	4a. Facility Name (If not institution, gi		1		or Location of Dea		4c. County		
		Ř	Washngton Advents 5. Social Security Number 6.		e (In yrs. last birthday)	If Under 1 Yea	coma Park		Mon	tgome	
	Funeral Director			1□M 2XF	82 Yrs.	Months Days					place (State or Foreign htry) hington, D(
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	the Mary 28a-f sh	Funeral Director	Maryland Montgo	mery	Silver						1⊠Yes 2 No
	with a or i	급	11235 Oakleaf Di	ive		10f. Zip Code 209	a∩1	11	0g. Citizen of V USA	What Cour	ntry?
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.1			Specify Ves or No-		a - Amori	an Indian.
36	init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "naturel", or items 23a or 28a-f show injury or other traumatic event, Ite Mudical Examiner must be notified at 8e.	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, specify Cul		Specify Yes or No- rto Rican, etc.)		ck, White,	
Maryland 21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Bu	isiness/In	duetry
215	hin 7:	Completed	(Specify only highest gr Elementary/Secondary (0-12)	a de completed) College (1-4or 5	(Give	kind of work done DO NOT use retir	e during most of wo	orking	rob. rang or be	3011033411	dustry
7	filed with Hygiene. other than	50	12			t Agent	- Amtrac	k	Rail	Lroad	
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last					me (First, Middle, N		10)	
yla	2 should be f and Mental R Is marked of aumatic eve	၉	Milton C. Murra				1	es J. Spi			
Jar	2 sh and rsm raum		19a. Informant's Name/Relationship					ural Route Number,			
	1 and 2 Health tem 27 I		Curtis L. Higbie 20a Method of Disposition	e – Son	20b. Place of Dispo		of Dr, #9	10, Silve			
Š	Pages nent of H ant: If ite ury or ot		1 ☐ Burial 2 X Cremation 3		cemetery, crer	natory or other pla			20c. Location -		
Baltimore,	permit. Page Department of Important: If eny injury or once.		* 4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Septice Lice		Metropolita			24/2004 A			
Ba	permit. Departrimports eny inju		21. Signature of Funaral Setvice taxe	11/100				asch's Fu			
	@)		23a. Parl1. Enter the disease, or comshock, or heart failure. List only	plications that caused						FID Z	Approximate
	Physician		Immediate Cause (Final	//-		, h	11+0	less of			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	u FM pol a consequence of):	CTUN	6 L 10	recou			7/20/04
	Examiner	_	Sequentially list conditions,	b. GROU	A posiho	E Bay	lenem	w			7/21/04
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Ċ,	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	c. Due to for as	a consequence of):	come	Cin Hi	<i>16</i> -			1/24/04
1760,	# × 6	icai	(a Respo	roctory o	listress					7/21/04
68	rtifica ng ph	Med	IF FEMALE:		-						
Вох	eath certific attending pl	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnanc	:v			e of delive	•
0.	the a	Physician/Med	1 Yes 2 No	4□Pregnant at 9□Unknown		Other (specify)			Mor	ntn	Day Year
<u>α</u>	that the de led by the a detached		Part II. Other significant conditions	contributing to death by	it not resulting in the ur	derhing cause a	von in Bort I	230 Did tobe	2000 1100 0001	ib. do lo dh	e cause of death?
Records,	quires an signe uld be	d by	1	elor	ar not reconstring in the di	idenying cause gi	VOIT II II ZILI.	1 ☐ Yes			ably 4 Unknown
202	w requ been shoul	Completed	^	_	01	4					
Re	The lav	ш			Chemo &	Roude	chin'	24a. Was an autopsy perform	р	Vere autop rior to con leath?	sy findings available apletion of cause of
Vital			25. Was case referred to medical	rnia.				1 Yes 2	No 1	Yes	2 No
⋝	Physicien: this certific ral director,	o Be	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpatien	2 DOA Ot	her	ath (Check only one		10 11	
of		-	27. Manner of Death	28a. Date of Injur	y 28b. Time of	28c. Inju	ry at	dome 5 Resider 28d. Describe how)
jo	c = -	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year) Injury	M 1	rk?]Yes 2∏No				
Division	iel or Attending s after death. el Director: After ed in by the fune	Certification:	3 Suicide 6 Could not b		rry - At home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Numbe	er or Rural	Route Number,
	itel o rs aft rel Di	Cer		Danding, oto	. (Орвону)			City of Town,	Siale)		
	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in D	Medical	29a. Certifier (Check only one) 1 Certifying Properties 2 Medical Exer	nysician: To the best on miner: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the ti restigation, in my	me, date and place opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and mar e and place, a	nner as sta	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number	296	d. Date signed	(Month, E	Pay, Year)
			1 alhabia	Vacan	me, Mn	00	060443		7/22	loci	
	100		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, I	Print)	CENTOON		. [0.0]	177	
	UK (6)		Nathallie N	ARCISSE	7600	Carro	11 Aven	ue tal	oma	2010	KMD.
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 200		r's Signature						

		- State Registrar					Ce	rtifica	ate of	Death			Reg. No.	UU4	2594
Physicia	en in	Decedent's Nam-										2. Date of De Month		Year	3. Time of Dea
/Medica			hael									07	19	04	3:59P.
Examine	ęr	4a. Facility Name (et and number	")			•	r Location o	f Death			County of Dea	
	5	19566 Fi		6. Sex	7 A	ge /ln vrs	last birthday		der 1 Year	ville	24 Hrs.	8. Date of Bir		ontgom	
uneral rector		577-78-8 Usual Residence of	3406	1 [3 KM	2 🗆 🗷	47	Yrs.	Month		Hours	Min.	8. Date of Bir (Month, Da 05 28			rthplace (State or For country) horage, Al
how		10a. State	10b. County	У		10c. City	y, Town or L	ocation							10d. Inside City Lir
illiand s	cto	MD	Montg	gomery		Po	oolesv	ille							1X Yes 2
or 28	Funeral Director	10e. Street and Nui	mber					10f. 2	Zip Code				10g. Citiz	en of What C	ountry?
236 IMM	E .	19566 Fi	sher A						20837					SA	
Item Cern	nue	11. Marital Status	ind 20 Mar	/	Was Decedent	?	.S. 13.	Was Dec	sedent of H secify Cuba	ispanic Orig an, Mexican	jin? (Spe , Puerto f	cify Yes or No Rican, etc.)	- 1	 Race - Am Black, Whi 	erican Indian, ite, etc.
P. O.	by F	1 ☐ Never Marr: 3 🛣 Widowed		, 1	1 □ Yes 2 🔀 If Yes, Give Year or Dates:			1 🗆 Yes	2 🙀 №	Specify:				Specify: B1	ack
atura cut E			15. Deceder	nt's Educatio	on		16a. Dece	edent's Us	sual Occup	ation				d of Business	
Ma.fi	pie	(Spec	ondary (0-12)		mpleted) College (1-4or	54)	(Give	e kind of v DO NOT	vork done i use retired	during most	of workir	19			
er tha	Completed				1 yr.	3+)	Vet	erina	arn T	echni	cian		Asso	veteri ciatio	nary Refer n, inc.
d oth	Be	17. Father's Name	(First, Middle,	, Last)						18. Mothe	r's Name	(First, Middle	Maiden S	umame)	
arkec atic e	2	George	Clinto	n Holl	ley					Fran	nces	McGhee	!		
item 27 is marked other than "natural", or items 23s or 28a-1 show other traumatic event. If a Medical Exact it are must be rediffied at	- 1	19a. Informant's Na	ame/Relations	ship (Type, I	Print)		19b. Mail	ing Addre	ss (Street	and Numbe	r or Rura	Route Numb	er, City or	Town, State,	Zip Code)
tem 27 is r	-	George C	Holl	ey/Fat	ther	001 B	710_	Delai	field	St. 1		Washir			
at ite		20a. Method of Disp 1 Burial 2		3 □Remo	oval from State	206. P	lace of Disp emetery, cre	osition (N amatory or	lame of r other plac			ate		-	Town, State
Important: If item 2 any injury or other once.	-	¹ 4 □ Donation	5 Other (S	Specify)		Lir	ncoln				-26-			and, M	
Impor any in once.		21. Signature of Fu	ineral Service	Licensee	- O		2					shall's			
= e Q	1	78	ma	isho	ell									1, D.C	. 20011
edical		disease or condition resulting in death)	(Final on	a	Arrhy	thmia		iter the mo	ode of dyin	g, such as o	cardiac or	respiratory a	rest,		
miner ial-transit	Exal	disease or condition	nditions, nmediate erlying injury	a b c	Arrhy Due to (or as Myoca Due to (or as	thmia s a consequ rdial s a consequ tensi	uence of): Infa: uence of): ve &	rct					rest,		Interval Between
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OK as is not int

Physician /Medical Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician

/Medical Examiner

Funeral

Director

rai, or items 23a or 28e-f show Examiner must be notified at

naturai

Director

ģ

DC

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic avoid.

> attending physician and for use as the burial-transit signed by the a been sig page 2

Physician/Medical þ Be Completed Certification: To cal

resulting in death) Last	Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Yea
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unki
		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings ava prior to completion of caus death?
25. Was case referred to medical examiner?	26. Place of Death	Check only one)
1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day reer) Injury Work?	28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28l. Location (Street and Number or Rural Route Number, City or Town, State)

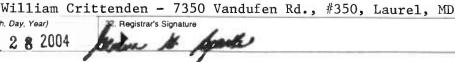
State Registrar

31. Date filed (Month, Day, Year) 2 8 2004

29b. Signature and little of certified

29a. Certifie

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4316146

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

To the Hospitel or Attending Physician:

within 24 hours a To the Funeral D

		1 - For State Registrar		aryland / Do	epartmen Certificat			and M		Reg. Ne.	fill file	25945
	sician								2. Date of Dead		Year	3. Time of Death 1241 PM M
	edical miner	4a. Facility Name (If not instituted in the second second in the second second in the	le #560		Solon	ans	Location o				County of Death	
Fune Direct		5. Social Security Number 226 58 4960 Usual Residence of Decedent	15€M 2□F 8	ge (In yrs. last birth Yı	Months	Days	If Under 2 Hours	Min,	8. Date of Birt (Month, Da March 14	h Y, Year) 1921	9. Birth Cou North	place (State or Foreign ofty) Carolina
e Maryland 3a-f show	oto	10a. State 10b. Cou	•	10c. City, Town								10d. Inside City Limits 1 ☐ Yes 2 ☐Ño
h with th	al Directo	10e. Street and Number 11665 Asbury Cir	cle # 560		10f. Zip	Code 0688				10g. Citi: Unit e	zen of What Cour ed States	ntry?
perillinities, interpretain a Lation of permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Itam 27 is marked other than "natural", or Items 23e or 28e-f show may interpretain or Items 25e or 28e-f show may interpretain or Items 25e.	hv Funeral	3 ☐ Widowed 4 ☐ Divor	If Yes Give	?	13. Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto i	city Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: Whi	etc.
d within 72 ho jiene. r than "natur	Completed	15. Dece (Specify only high	dent's Education phest grade completed) 2) College (1-4or 5+	5+)	Decedent's Usua Give kind of wo ife. DO NOT us	rk doné d se retired)	uring most)	of workin	ng		nd of Business/In	
Id be filed ental Hyg kad othe	To Be	17. Father's Name (First, Mide	die, Last)		-		18. Mothe	r's Name th Ya	(First, Middle,			
INIGITY The stand Mark Mark Mark Mark Mark Mark Mark Mark	-	19a. Informant's Name/Relati Maryalice F. Huff			Mailing Address 5 Asbury						Town, State, Zip	Code)
Deficiency of the permit. Pages 1 are Deportment of Hearn moortant: If Itam movinium or other		20a. Method of Disposition 1	on 3 □Removal from State r (Specify)	20b. Place of Cometery,	Disposition (Nar crematory or o itan Fun	ther place	July Ervio	30 X	ate 004		cation - City or To	
Dermit. Dep.rtm	Suce	21. Signature of Euneral Serv	rice Licensee		22. Name an			Nau	ech Fune			
Physici /Medic	cal	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	a	d the death. Do not ine. Onany cost a consequence of the consequence	t enter the mod	e of dying	g, such as	cardiac o			20070	Approximate Interval Between Onset and Death
cate be executed EX SX SX SX SX SX SX SX SX SX SX SX SX SX		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	lt.	atro	<u>m</u> 1					4 years
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law requires that as been signed by	Ad vd be	Part II. Other significant con-	ditions contributing to death! soms m	out not resulting in t	he underlying c	ause give	n in Part I.		23e. Did to		/	ne cause of death?
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Jn OI ding Phy After this	T. doi:	examiner? Yes 2 No	Hospital: 1 Inpati 28a. Date of Inj inding (Month, Da	ury 28b. Tir		Bc. Injury Work	r: 4 □ Nur at	rsing Hon	(Check only one 5 X esices 18d. Describe h	lence 6	☐Other (Specify occurred	y)
pital or Atteory after de laral Diracte	Cortific	3 Suicide 6 Co	uld not be ermined 28e. Place of In building, e	jury - At home, farn tc. <i>(Specify)</i>	n, street, factory	, office		2	PBf. Location (5 City or Tow		d Number or Rura	Il Route Number,
To the Hospital or Attand within 24 hours after death To tha Funaral Director:	protein min		fying Physician: To the best cal Examiner: On the basis of and manner s	of examination and/	death occurred or investigation	at the tim , in my op	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
To ti To ti		29b. Signature and title of cer			290	License		-/-		-	signed (Month,	
N.		30. Name and address of per-	son who completed cause of	death (Item 23a) (T			5 (5	5 60		70	1427,	2004
10	State		, M.D. H.G. Truen ear) 32. Regist L 2 8 2004									
Reg	gistraı	30	L Z & ZUU4 P	MARINE S	- 15 M							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 501 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year July 25,2004 Joachim Huebner 11:09 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2022 Boyds Trail Calvert Owings 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 1943 Birthplace (State or Foreign Country) **Funeral ™** M 2□ F Months Days Hours Yrs. Director 213-42-8489 61 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director MD Calvert Owings 1 Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2022 Boyds Trail 20736 or Itams 23a U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 10 Yes 2 No If Yes, Give Year or Dates: 1961-64 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If itam 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4 or 5+) auto technician auto repair 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Ilse unknown Horrch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helga Huebner, wife 2022 Boyds Trail, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Permoval from State
4 Donation 5 Other (Specify) Metropolitan Crematory 07/27/04 Alexandria, VA 21. Signature of Funeral Service Acer 22. Name and Address of Facility once. Rausch Funeral Home P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fearly failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Prostate disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-t Due to (or as a consequence of) Records, P.O. Box 68760. physician Physician/Medical as the attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown ል Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sec page 2 autopsy this certificate Division of Vital 1 ☐ Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. thours after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours af To tha Funarai D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital stress Signature 111 Prince Frederick Arct 32. Registr 31. Date filed (Month, Day, Year) State 2004 Registrar

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	Mith Ba or	흐		elena Dri	V/A			10f. Zip Code 206	78			10g. Citizen o	USA	ntry?
	death	Funeral	11. Marital Status	CICIA DII	12. Was Decedent	Ever in U.S.	13. Wa	s Decedent of Hes, specify Cubi		rigin? (Specify	Yes or No-	14. R	ace - Ameri	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Itam 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, it a Medical Example in traumatic event, it a Medical Example is not in the inclined at	2	1 Never Marr 3 Widowed	ried 2. Married 4 □ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	[№] 1943–45		es, specify Cubi	an, Mexica Specify		in, etc.)	Spec	lack, White, cify: Wh	etc. nite
5-0	72 ho Instur	eted	(Spec	15. Decedent's Ed		16a.	Deceden (Give kin	t's Usual Occup d of work done	ation during mo	st of working		16b. Kind of	Business/In	dustry
121	within sne.	Completed	Elementary/Seco		College (1-4or :	5+)		d of work done NOT use retired 1 Teach		g		Dub1	ic Fd	cation
CA	12 should be filed within "h and Mental Hygiene. 7 is marked other than "iraumatic event, the Mer		17. Father's Name	(First, Middle, Last)			CHOO	1 leacii		ner's Name (Fi	rst. Middle.			ication
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Maryland	2 shou and N is mai		-	ame/Relationship (7	Type, Print)			Address (Street			oute Numbe	r, City or Tow		
	and 2 ealth n 27 i				Harper (h	usband)		Helena		ve Pri	nce F	rederi	ck, M	20678
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Itam 27 ti any injury or other tra <u>QDC8</u> .		20a. Method of Dis 1 St Burial 2		Removal from State			on (Name of ory or other place		August	17,	20c. Location	-	
Ë	t. Partmen		° 4 ☐ Donation	5 Other (Specify uneral Service Licen	<i>(</i>)	Arlin	_	Nat. C		2004		Arlin		
Ba	permit. Departrimports any inj		21. Signature of/Fi					ame and Addre						ert, PA MD 20736
			23a Part 1. Enter	Gary J. G	olications that caused	the death. Do n	_					_	mgo,	Approximate
S.	Physician		Immediate Cause disease or condition	(Final	one cause on each li	no.	ic.	CVA					4	Interval Between Onset and Death
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н	Examiner		Sequentially list co	onditions,	b. HTW	V								
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	ne dea the at hed fo	/sici	1 Yes 2	No	4□Pregnant a 9□ Unknown	t time of death		ther (specify)					Month	Day Year
P.0	res that the de igned by the a be detached f	Phy			ontributing to death b	out not resulting in	the unde	riving cause giv	en in Part	l.	23e. Did to	bacco use co	ntribute to t	he cause of death?
Records,	8 20	ed by									1 □ Y	es 2X No	3 ☐ Prob	pably 4 Unknown
000	aw requires s been si 2 should 1	Completed									24a. Was a		. Were auto	ppsy findings available
Ä	The ate h page	mo.									autop: perfor 1 Yes	med? 22 No	death?	mpletion of cause of 2 ☐ No
of Vital	Physician: The lav this certilicate has ral director, page 2	Be	25. Was case refe examiner?	rred to medical						e of Death (C)				
of	Physi this c	2	1 ☐ Yes 2 2 27. Manner of Dea	(No	Hospital: 1 Inpatie	-		3 DOA Oth	4 🗆 14	lursing Home				ý)
O	ding th. Th. After funer	tion	1 Natural 2 ☐ Accident	5 Pending investigation	(Month, Da		njury	28c. Injur Wor M 1	yat k? Yes 2.⊑		Describe n	ow injury occ	urrea	
Division	I or Attending after death. Director: After	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj	ury - At home, far	m, street		2753	28f.	Location (S	treet and Nur	nber or Rura	al Route Number,
Ö	tal or A	Certification;	4 Homicide		building, et	c. (Specify)					City or Tow	n, State)		
	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	edical	29a. Certifier (Check only one)	Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	f examination and	, death or	curred at the tir tigation, in my o	me, date a pinion, de	and place, and path occurred a	due to the o	ause(s) and r late and place	nanner as s e, and due to	tated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier		^		29c. Licens			2	29d. Date sign	ned (Month,	Day, Year)
			NUU	MON	V2 M.	U.		200	60	175		4/20	104	
(3+1		30. Name and add	ress of person who	completed cause of c		Type, Pri		0.0	PPIN		EVED	ICV	MD 20678
	Sta	ate	31. Date filed (Mor	nth. Dav. Year)	32. Registr	a Signature				1 -110	CTK	CUCIC		711200
	Regist			JUL 2	2 2004	House .	H.	pour						
DH	VIH 17 Rev 1/2	2001												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 501. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat **Physician** Ju^{Month} 31, Day 2004 Year 10:15AM K. Flanary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Williamsport Washington 11339 Kempsmill Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2√2 F 59 220-42-2311 Yrs. Director July 17,1945 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 TYes 2♥ No Directo Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 11339 Kempsmill Road 'natural', or Itams 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant filled or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be it. Pages 1 and 2 should be ultiment of Health and Mental intant: If Itam 27 is marked o Titus Nancy Jarels David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 907 Orchard Manor Dr., Boonesboro, MD 21713 19a. Informant's Name/Relationship (Type, Print) April Berens/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gards 8/5/2004 Frederick, MD permit.
Departn
Imports
any nju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator Priysician 1249 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of): Examine death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 No 1 ☐ Yes 2 12 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred a Hospital or Attending P 24 hours after death, a Funeral Diractor: After t After 1 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 August 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick imp 21702 Hudhad, MD . 468 Thomas Blussen . Registrar's Signature State Registrar

Registrar		Cei	rtificate of	Death		F	Reg. No. U	JU	C + C C 7
Decedent's Name (First, Middle, Last) Clan Table (OND) Table (OND) Table (OND) Table (OND)						Date of Dea Month	ath Day	Year	3. Time of Death
dical INMOND S. HIC						JULY	31 20	004	11:50 A
4a. Facility Name (If not institution, give si			4b. City, Town,					nty of Death	
Holy Cross Hospit 5. Social Security Number 6. Sex	7. Age (In yrs.	(act hirthday)	Silver	-		Posts of Rie		ntgome	
254-22-8375 ¹ 2	M 2□F 7.7	Yrs.	Months Days		Min.	8. Date of Birt (Month, Day March	y, _{Year)} 3 1927	Flor	place (State or Foreigntry) dia
Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or Lo	ocation					1	0d. Inside City Limit
Q NO Professor Co.	1-	Beltsv							ty⊡Yes 2□N
MD Prince Geo	orge s	Delley	10f. Zip Code				10g. Citizen o	of What Cour	ntry?
10405C 46th Avenu	ie # 302		2070)5			U.S.	. A .	
MD Prince Ger 10e. Street and Number 10405C 46th Avenu 11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married	2. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of	Hispanic Ori	gin? (Spec	rify Yes or No-	14. R	ace - Americ	
3 ☐ Widowed 4 ☐ Pivorced		2777	1 ☐ Yes 2 ☒ No		., , , , , , , , , , , , , , , , , , ,		Spec		Black
15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12)		16a. Dece	dent's Usual Occu	pation	t of workin	_	16b. Kind of	Business/Inc	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	t or working	9			
CO	2 yrs	Barb	er				Priva		
17. Father's Name (First, Middle, Last)				18. Mothe			Maiden Suma	ame)	
ျှေ Inmond Hick				Emm		iffin			
19a. Informant's Name/Relationship (Typ	•		ng Address (Stree		_	_			Code)
Linda C. Hicks/ 20a. Method of Disposition	Daughter		Elm Str		nnam,		and 20c. Location	20706	State
1 🖫 Burial 2 Cremation 3 Re	mioval ilotti State		osition (Name of matory or other pl	1					
' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			Veteran		3/6/20				Maryland
10a. State 10b. County MD Prince Ge. 10e. Street and Number 10405C 46th Avenu 11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Inmond Hick 19a. Informant's Name/Relationship (Type Linda C. Hicks/ 20a. Method of Disposition 1 Burial 2 Cremation 3 Relationship (Specify) 21. Signature of Funeral Service License	shall		2. Name and Addi 474 Land				nkins F er, Mar		
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	e cause on each line.	ith. Do not en	ter the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
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			1	For State Registrar	State of	Marylar				lealth ar <i>Death</i>	nd Me	ental Hy	giene Reg. Nd.	00	3 /	25950
				Decedent's Name (First, Middle, La	st)						2	. Date of D	eath Day		eer	3. Time of Death
		Physicia /Medic		Lawrence Allen	Hite							July	27,	200		6:15 P ^M
		Examin		4a. Facility Name (If not institution, giv	e street and num	ber)				or Location of I	Death		4c.	County of	Death	
				Casey House				Rock	vill r 1 Year		l Hen I a			ntgo		
		Funeral Director		5. Social Security Number 146-66-7083 Usual Residence of Decedent	ex 7 XXM 2□F	7. Age (In yrs. 4		Months			Min.	B. Date of B (Month, D OV • 2	av. Year)	61 (Counti Cali	ace (State or Foreign y) fornia
)	/land	Mod		10a. State 10b. County		10c. Ci	ty, Town or L	ocation.							10	d. Inside City Limits
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+	h with	23a or ast be	o ie	304 Soapstone Lan	ne			209	05				USA			
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76	ours after	0 5	by	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	2 X No		1 ☐ Yes						Specific	√hit	
Lawrence Manyand 21215-0036	filed within 72 hours after	th and Mental Hygiene. 7 Is marked other than "natural", traumatic event, the Modical Exa	Completed	15. Decedent's E (Specify only highest gr. Efementary/Secondary (0-12)	ade completed) College (1-	4or 5+)	(Give	DO NOT L	ork done ise retire	during most o d)				nd of Busin	ness/Indu	ustry
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acc		- 0 %	Be	17. Father's Name (First, Middle, Last Charles Carroll 1						Phy11				Surname)		
1 2	should	d Mer nark natic	To	19a. Informant's Name/Relationship			19h Mail	lina Address	s /Straat	and Number				Town St	te Zin (Code)
2	710	th an		Thomas B. Stahl/		/ POA		-					-			d 20905
9	7, G.	Heal tem S		20a. Method of Disposition			Place of Disp cemetery, cre	osition (Na	me of	cal	JuI ^{Da}	te 29	20c. Lo	cation - Ci	y or Tow	m, State
9	3908	ant of an		1 ☐ Buriaf 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from S	late	Arund				200		0den	ton.	Mar	yland
100		Department of Health and Monta Important: If I lem 27 Is marked any injury or other traumatic or 20028.		21. Signature of Funeral Service Lice			Ğ	22. Name a	nd Addre Home	ess of Facility	tion	Serv	ice	P.O.	Вох	784
				23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that ca	used the dea								rksv		MD 2102 Approximate Interval Between
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	Hoodi	24 hours 24 hours Funeral etely fille	Medical C	29a. Certifier 1X Certifying P (Check only one)	hysicien: To the miner: On the ba and mann	sis of examin	owledge, dea ation and/or i	ath occurred investigation	d at the ti	me, date and opinion, death	place, an	d due to the d at the time	e cause(s) , date and	and mann place, and	er as sta I due to t	ted. the cause(s)
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	/			I Chiti sh	pup	al		D	-424	52			July	28,	2004	4
	(10/10		30. Name and address of person you	completed cause	e of death (Ite	m 23a) (Type	e, Print)								
	_	100		Chitxa Rajagopal	M.D. 1	8111 P	rince	Phili	p Dr	#327	Oln	ey, M	D_208	32		
		Sta Regist	ate rar	31. Date filed (Month, Day, Year)	1 20 0	strar's Sign	antices.									

Registrar

		1	_ State	State of Mar	yland / Depa	artment of H			iene	1. 250	152
			Registrar 1. Decedent's Name (First, Middle, Last)			timouto or a		2. Date of Death	n	3. Time	of Death
п	Physicia	_	Elizabeth Mills HE	LM				August :		1:30	a. M
7	/Medic Examin		la. Facility Name (If not institution, give str			4b. City, Town, or		h	4c. County of		
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	Funeral		5. Social Security Number 6. Sex	L OFFE	In yrs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		rear)	9. Birthplace (State Country) Tennesse	
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	-f st	to	Maryland Washin	gton	Hagers	town					es 2🕅 No
	or 28	Directo	10e. Street and Number			10f. Zip Code	0	10	0g. Citizen of Wh US		
	ath wi	ra L	9946 Downsville P		T: 110	2174		Sanata Van ar No		- American Indian,	
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "netural", or items 23e or 28e-f show event, the Medical Exeminer rust be notified at	by Funeral	11. Marital Status 1 1 X Never Married 2	. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🏻 No	Specify:	to Rican, etc.)		white	
ŏ	2 hou		15. Decedent's Educa (Specify only highest grade	tion	16a. Dece	dent's Usual Occupa	ation during most of wo	rkina	16b. Kind of Bus	iness/Industry	
21215-0036	thin 7 e. en "n M.d	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		govern	mant	
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and	ntal H	Be	William P. Helm				Lydia				
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other then "reumatic event, the Mental Hygiene"	ဥ	19a. Informant's Name/Relationship (Type	o, Print)	19b. Maili	ng Address (Street a	and Number or R	ural Route Number,	, City or Town, S	tate, Zip Code)	
Σ	and 2 sealth an m 27 is		Debbie Kinch -grea		1560	9 Wapello	o Way, D	erwood, M	ld. 2085	5	
ē,	s 1 ag f Hea item othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other plac	ea)			City or Town, State	
Ë	Page nent o unt: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	noval from State	Hagersto	wn Cremat				own, Mary	land
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic es		21. Signature of Funeral Service Licensee	/		2. Name and Addres		MINNICH FU			.0
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the	ne deeth. Do not en	ter the mode of dyin	g, such as cardia	ic or respiratory arre	est,	Approxim Interval E Onset an	Between
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P.0	g g g		Part II. Other significant conditions cont	nbuting to death but	not resulting in the	ınderlying cause gıv	en in Part I.	23e. Did tob	bacco use contri	bute to the cause of	of death?
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Division	tten deat stor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, farm, si					r or Rural Route N	umber,
۵	i or Atten after deat Director:	ert	4 Homicide	building, etc.	*(Specify)			City or Town	n, State)		
	To the Hospital or A within 24 hours after to the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Gertifying Physical (Check only one)	cian: To the best of er: On the basis of and manner state	examination and/or in	th occurred at the time	me, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and mar ate and place, a	ner as stated. nd due to the caus	Θ(s)
	To the within To the complex c	₩	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year	
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r	HAILY OF		30. Name and address of person who con			Print)	CERSTO	wa me	217	40	
9	St Regist	ate	31. Date filed (Month Day Year) 2 20	32. Redistra	r's Signature	Speck					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Patrina V. Hines 15, 2004 8:10 A July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 444 Riverview Drive Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 2-23-1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**F 579-22-4347 82 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 🛮 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 444 Riverview Drive 21037 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Interportant: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Evantina once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: þ Specify 3 ☐ Widowed 4X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosario Vezzi Giuseppa Di Gregorio 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Hines/ Son 478 Riverview Dr., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Warial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemetery 7-19-04 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 5/498 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First Uncertaint Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the deat certificate be executed and burial-tran Due to (or as a consequence of) noing physician a Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No to o Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the Ś signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 2 7 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature aportitle of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) Ja+the. Holida. Ma 1+ 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1 - State Registrar Ce	partment of Health and Mertificate of Death	Reg.	2111b	25955
	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> Parveen Rostami Habibi		2. Date of Death July 21	P ^{ey} , 2014	3. Time of Death 8:00 р.м
}	Examin		4a. Fecility Name (If not institution, give street and number) 5338 Norbeck Road	4b. City, Town, or Location of Death Rockville		4c. County of Death Montgome	ry
	Funeral Director		5. Social Security Number 426-06-7824 6. Sex 1 M 2 M F 62 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 05/24/194	9. Birthp Coun	ace (State or Foreign try) Iran
	Maryland f ehow	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I Maryland Montgomery Rockvi		* · · · ·	1	0d. Inside City Limits
	or 28a-	Direct	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "naturel", or items 23s or 28s-f ehow eny injury or other treumatic event, it a Mudical Examinar must be notified at once.	by Funeral Director	5338 Norbeck Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	20853 Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto 1□Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	Iran 14. Rece - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	should be filed within 72 ho nd Mental Hygiene. marked other than "natur imatic event, it a Mudical	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) Hom	edent's Usual Occupation e kind of work done during most of work. DO NOT use retired) emaker	ing	Own Home	lustry
land	uld be fil Aental H rked otl	To Be	17. Father's Name (First, Middle, Last) Nasser Gholi Rostami		_{e (First, Middle, Maid} reh Ansari		
, Mary	C/ 10 = 0		Ninta Habibi , Daughter 22	ling Address <i>(Street and Nu</i> mber or Rura 21 Hunter Mill Road		ty or Town, State, Zip Y , Virgin	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other to once.		• 4 □ Donation 5 □ Other (Specify) Sterli	ng Cemetery 07/2	22/04	Location - City or To Sterling, V	irginia
Balt	Depart Import eny in		21. Signature of Funeral Service Licensee Culillians Mulaway Ca 1	22. Name and Address of Facility Lou 58 Catoctin Circle	udoun Fune , SE 20175	eral Chape Leesburg	l,Inc. ,Virginia
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that gaused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nter the mode of dying, such as cardiac of	or respiratory arrest,	c	Approximate Interval Between Onset and Death
8760,	te be executed ysician and te buriat-transit	Ical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
.O. Box 687	death certifica e attending ph id for use as th	Physician/Medic		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
s, P	20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	
I Record	The law ate has t	Completed			24a. Was an autopsy performed	prior to cor	osy findings available inpletion of cause of
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical sxaminer? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Othon	h (Check only one)	e 6 □Other (Specify	•)
Division of Vital	Attending Physic death. Cotor: After this by the funeral di	atlon; T	27. Manner of Death Lack Accident 28a. Date of Injury (Month, Day Year) 28b. Time Injury (Month, Day Year) 28b. Tim	of 28c. Injury at	28d. Describe how in		,
Divis	F 0 F C	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	Route Number,
	To the Hospital c within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal control	ith occurred at the time, date and place, investigation, in my opinion, death occurr	and due to the cause red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier Additional control of the certifier	29c. License number 53(77	29d. 5	Date signed (Month, I	Day, Year)
			Paul M. Thambi M.D. 9707 Medical C	enter Drive Suite	#300 Rock	ville,MD.	20850
5	Sta Regist	ar	31. Date filed (Month, Day Year) 8 200 4 32. Registrar's Signature	& Sports			
UF	IMH 17 Rev 1/2	JUI					

DHMH 17 Rev 1/2001

ORIGINAL

				State of Maryland / Dep				
			1 - State Registrar	-	rtificate of Death	ia montai rij	Reg. No.2 11 11	25056
8	Dhysis	()	1. Decedent's Name (First, Middle, Last)		2. Date of Do	hom.	3. Time of Death
	Physici /Medi		Fanny Mae			July 2		12:55 A ^M
	Examir	er	4a. Facility Name (If not institution, give		4b. City, Town, or Location of	Death	4c. County of De	ath
			Anne Arundel Medi 5. Social Security Number 6. Se		Annapolis If Under 1 Year If Under 24	Hrs 0 Date of B	Anne Ar	
	Funeral Director			x 7. Age (In yrs. last birthday, Yrs.	Months Days Hours	# Hrs. 8. Date of Bi (Month, Di 4-4-19	ay, Year) 9. Bi 930 Vi	rthplace (State or Foreign Country) rginia
	yland		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
	B Mar	ctor	Maryland Anne Ar	undel Edg	ewater			1 ☐ Yes 2 🛣No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	country?
	s 23a		5 Puddington Road	12. Was Decedent Ever in U.S. 13.	21037	2/2 / /	USA	
36	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23s or 28s-f show matic event. The Medical Exartane must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	Amed Forces? 1 □Yes 2 TXNo	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Canaiha	
0	72 hou		15. Decedent's Edu	ication 16a. Dece	edent's Usual Occupation		16b. Kind of Business	
215	within 7 ene. than "r	Completed	(Specify only highest grad	College (1-4or 5+)	kind of work done during most of DO NOT use retired)	f working		
21	filed with Hygien Hygien other the		9	Own	er-Operator		Seafood Re	staurant
pue	tal H	Be	17. Father's Name (First, Middle, Last)		18. Mother's	Name (First, Middle	,	
2	hould d Mer marke matic	2	Wilbur Po		in Address (Chron and Alicenter	Lula Ma		7. 0
Ma	id 2 s ith an 27 is i		1		ing Address (Street and Number			Zip Code)
Je,	s 1 and 2 of Health a item 27 Is othar trau		Janice F. Walls/ 20a. Method of Disposition	20b. Place of Dispo	Claiborne Rd., osition (Name of	Pogewater,	20c. Location - City or	Town, State
Ë	Page: ient o nt: If ry or		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	nemoval from State	matory or other place) Cemetery 7-	31-04	Davidson	ville, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		21. Signation of Funeral Service Licens		2. Name and Address of Facility	George P.		
<u> </u>	825 5 8	h k	16 mit a cuche		973 Solomons Is			
* * *	Physician		23a. Part1. Enter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do not en ne cause on each line. a. Chronic Obst				Approximate Interval Between Onset and Death
4	/Medical Examiner		Tobaling in county	Due to (or as a consequence of):				
260	with a	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Uue to (or as a consequence of):				
	ate be executed ysician and he burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	a exec		resulting in death) Last	Due to (or as a consequence of):				
3760,	ate be hysici	ical		d				
× 6	ertifica ling pl	Med	IF FEMALE:					
P.O. Box 68	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 54 hours after death. To the Functal Director: Alter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
۵.	that hed by deta	y Ph		ntributing to death but not resulting in the u		23e. Did t	obacco use contribute to	the cause of death?
Division of Vital Records,	e law requires tha has been signed je 2 should be de	q pe	Multifocal A	trial Tackyca Heart Failure	ardia	1	Yes 2□No 3☑P	robably 4 Unknown
00	s bee	plete	Congestive 1	Heart Failure		24a. Was	an 24b. Were at	utopsy findings available
Ä	The I	mo)			— autor perfo 1 ☐ Yes	rmed? prior to death?	completion of cause of
ita	ysician: The I is certificate he director, page	Bec	25. Was case referred to medical examiner?		26. Place of	Death (Check only o		20140
5	Physic this co	ဥ	1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2 ☐ ER/Outpatier	The second secon	ng Home 5 🗆 Resid	dence 6 □Other (Spe	cify)
חכ	iing F	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	111	now injury occurred	
S	l or Attanding P after death. Director: After t I in by the funera	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str	M 1 Yes 2 No		Street and Number or Ri	um I Davida Atumba
<u>></u>	ital or A rs after ral Dire	Certification;	4 Homicide determined	building, etc. (Specify)	eet, factory, office	City or Tov		arai Houte Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of my knowledge, death ner: On the basis of examination and/or in- and manner stated.	h occurred at the time, date and p vestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the To the comp	N.	29b. Signative and title of certifier	2	29c. License number		29d. Date signed (Mont	
			Japhin XX	how my	000587	-37	3/28/04	
				impleted cause of death (Item 23a) (Type,	Print) rundel Medica	10-1-	Annapo.	lis, MD
	01-		Stephen & Shav	MD Anne A	rundel Medica	al center	21401	,
	Sta Registra		AR 2 S 20	32. Régistrar's Signature	Sand o			

			1- State RegistrerAMEND#1 per 1	olState of Ma 2/04 CMH		artment of Hertificate of L			ene	F1 F2 F1 PM MI
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Rosan	nna Beth H		terr =	2. Date of Death Month 0.7		3. Time-of Death
}	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			Anne Arundel Medi	cal Center		Annapolis	S		Anne Aru	ındel
	Funeral Director		1/4-48-3886	x 2 ½ F 7. Age 47	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 16-21-19		rthplace (State or Foreign country) ennsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl 1 sho	ō	Maryland Anne Aru		,					1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	28a	rec	10e. Street and Number	nder		Harwood 10f. Zip Code		100	g. Citizen of What C	
	h with	D	3017 White Beech D	rive		2077	76		USA	,
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Department of health and Mental Hygiene. Department: If item 27 is marked other than "neturel", or items 23e or 28a-1 show eny injury or other treumatic event, Ite Madrel Ext. ill but and be neithed an once.	Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2000		Was Decedent of His f Yes, specify Cuban			14. Race - Am Black, Whi	ite, etc.
2	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 X No	Specify:		Specify: W	hite
21215-0036	vithin 72 h ne. han "netu M. Jic.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa: kind of work done di DO NOT use retired)	uring most of work	ing		ironmental
	fygier fygier her ti	Col		5+ years	Enviro	onmental I				tection Agen
Maryland	d be findal Hed of	Be	17. Father's Name (First, Middle, Last)	Siubek Ciu				(First, Middle, Ma	,	
Ž	should d Me mark matic	은	19a. Informant's Name/Relationship (Ty			g Address (Street ar		rgaret Da		7: 0:43
<u> </u>	od 2 s lth ar 27 is r treu		W. Frederick Hoffn			White Bee				Zip Code)
ā,	s 1 ar f Hea item		20a. Method of Disposition		20b. Place of Dispo-	sition (Name of	1		c. Location - City or	Town, State
Baltimore,	Page: lent or nt; If i		1 ☐ Burial 2 【XCremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Kalas Cre	natory or other place	, 7–15–	Λ4 τ	- Edgewater	, Maryland
<u>=</u>	mit. partm porte r inju		21. Signature of Euneral Septice Licens	99		. Name and Address			Kalas Fun	
ñ	Deparent Dep		What o' under			973 Solom		nd Rd. Ed	gewater.	MD 21037
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Nonsma	ell cell	lung ca	MCEN			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a			, , ,			1011105
	LAUMINE	er	Sequentially list conditions)	consequence of):					
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	B as 10) of end	consequence or);					
	al-tra	Examin	that initiated events resulting in death) Last	Due to (or as a	consequence of):					
68/60,	icate be executed physician and the burlal-transit	dical		1						
Q										
P.O. BOX	leath certifi attending p	Physician/M	Zob. Was decedent program	3c. If yes, outcome of 1 ☐ Live birth 2		Ectopic pregnancy			23d. Date of de	livery
	e dea he att	sicie	in the past 12 months?	4☐Pregnant at tin		Other (specify)			Month	Day Year
ر د	res that the de signed by the a be detached f	Phy	9 Unknown					T		
Records,	ires the signer	by	Part II. Other significant conditions con	itributing to death but	not resulting in the un	derlying cause given	in Part I.	1.0	_	the cause of death?
0	w require been si should t	etec						1 Yes	2 No 3 Pr	obably 4 Dunknown
e	has l	Completed						24a. Was an autopsy performed	prior to	topsy findings available completion of cause of
0	sician: The certificate har		OF Man ages referred to madical					1 ☐ Yes 2 🗶		2□ No
5	sicia s certi	o Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	ospital: 1 Inpatient	2 T FB/O	Other	26. Place of Death			
ō	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of	28c. Injury a	at Nursing Hon	8d. Describe how	e 6 Other (Specinjury occurred	cify)
0	Attending F death. ctor: After y the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	ea <i>r)</i> Injury	Work?	es 2 🗆 No		,	
Division of Vital	for Attending Physician: The law requires that the death certifure death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru State)	ral Route Number,
_	To the Hospitel or Atten within 24 hours after deal To the Funerel Director: completely filled in by the	cai		sician: To the best of r						
	the I	Med	one)	and manner state	1.	100- 111-11		_ = uno, date	and place, and due	.5 210 00030(3)
	To wit		290. Signature and title of certifier	101 M	^	29c. License r	number	29d.	Date signed (Month	n. Uay, Year)
			and the state of		- Maria	0005	91.45		+/14/2)4
			29b. Signature and title of certifier Helman 30. Name and address of person who co Kottleen Kemm 31. Date filed (Month, Day, Year) JUL 19 20	mpleted cause of deat	n (item 23a) (Type, P Rontont	o Pol # 2n	s Anno	coolis n	11 214	01
	Sta	e	31. Date filed (Month, Day, Year)	32. Phistrar's	Signature	14,30	1711-14	7-17		- /
	Registra	ar	JUL 1 9 20	04	K A	worth 1				

			1 - For State Registrar	State of M	aryland .		artmen			and M	, ,	ene	nl.	25958
	Physic	an	1. Decedent's Name (First, Middle, Las	1)							2. Date of Death	1	V	3. Time of Death
	/Medi		Joan Humphries								July	27,	2004	3:15 p ^M
	Examir	ner	4a. Fecility Name (If not institution, give Anne Arundel Med.	,			4b. City,		Location o			4c. Cou	nty of Death	
	Funeral		5. Social Security Number 6. Se		e (In yrs. last	birthday)	If Under		If Under:		8. Date of Birth			Arundel
	Director			☐ M 2 🔀 F	80	Yrs.	Months	Days	Hours	Min.	(Month, Day, Sept. 2	Year)	9. Birthpi	ace (State or Foreign ry)
	pu »		Usuel Residence of Decedent 10a. State 10b, County		140. 00						Dept. 2	0,152	<u> </u>	
	e Maryla 8a-f shov	ctor	MD 10b. County Anne Anne Anne Anne Anne Anne Anne Anne	rundel	10c. City, T	own or Lo		erna	Park				10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	vith th	Director	10e. Street and Number				10f. Zip				10	g. Citizen	of What Count	ry?
	s 23g	eral	393 Stonehouse Di		Funcia III C	40.1	May Bassel		146	1 0 10			USA	
980	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or Items 23e or 28e-f show event, the Medical Evain for most be invitted at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		1	was Deced f Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		lace - America llack, White, e cify:	
2-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	10	6a. Deced	lent's Usua	l Occupat	tion	of workin	10	6b. Kind of	Business/Indu	ustry
121	within ene.	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	kind of wor DO NOT us	e retired) emak		0, 1,0,1,1,1	9		***	
0	filed Hygie ther is		17. Father's Name (First, Middle, Last)				поп			r's Name	(First, Middle, M.	aidaa Cum	Home	9
lan	should be nd Mental marked o	To Be	Michael Heidler								Davis	aiden Sum	ame)	
ary	. = . 3	-	19a. Informant's Name/Relationship (T)		II i	9b. Mailin	g Address	(Street ar	nd Number	r or Rurai	Route Number,	City or Tow	m, State, Zip C	Code)
Σ	and 2 ealth a n 27 ls		George Humphries	Husband		393	Ston	ehou	se Dr	ive,	Severna	a Parl	K, MD	21146
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke any injury or other treumatic Once.		20a. Method of Disposition 1 Burial 2 Commation 3 F 4 Donation 5 Other (Specify)		20b. Place ceme Meti	tery, cren	sition (Name natory or ot cemato	her place.)	July	29		n - City or Tow MO re, I	
Balt	permit. Departr Importa any inje		21. Sign turn it Funeral Service Licens	7//	,	B 22	Name and	d Address	of Facility Sons	, P.	A. Sever	ma Pa	ark Fun	meral Home
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused ne cause on each lin	cliac		er the mode	1/	such as o	e Hw	y, Sever respiratory arres	na Pa		21146 Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or a) Du	,									
.O. Box 6	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		Ectopic pre Other (spe		-				ate of delivery	ay Year
Records, P.	uires that n signed b	by	Part II. Other significent conditions cor Faeluse	ntributing to death bu	it not resulting	in the un	derlying ca	use given	in Part I.					cause of death?
CO	s been si	ojete	Genon0 5	2611.0							24a. Was an	24h	Were autops	y findings available
		Completed	Leukoaphs	1							autopsy performe		prior to comp death?	bletion of cause of
Vital	Physician: rthis certifica	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:				Othor			(Check only one)			
Division of	After After fune	ation: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		. Time of Injury	3 DOA 28	c. Injury a Work?	4 LI IAUIS	28	e 5 Residence dd. Describe how			
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At home, . (Specify)	farm, stre	et, factory,	office		28	of. Location (Stree City or Town, S	et and Num State)	ber or Rural F	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certified 1 Certifying Phys 2 Medical Exemin	sicien: To the best oner: On the basis of and manner state	exammation a	ge, death and/or inve	occurred at estigation, i	the time, n my opin	date and ion, death	place, an	d due to the caus I at the time, date	e(s) and m and place	nanner as state , and due to th	ed. le cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				-	License n			29d.	Date sign	ed (Month, Da	y, Year)
	1						\mathcal{V}	570	128	-		7/2	8/04	
			ame and address of person who co	mpleted cause of de	ath (Item 23a	(Type, P				Scul	2 231	A	eur Dot	'L MO
	Star Registra	- 4	31. Date filed (Month, Day, Year)		r's Signature	1	A)						7	21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Phyllis Hager 09, 2004 AUGUST /Medical 23:20 p.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Memorial Hospital CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar 25, 1919 Birthplace (State or Foreign Country) 1□M 25 F Director 215-16-4948 Yrs MD Usual Residence of Decedent death with the Manyland 10a, State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other fraumatic event, the Mudical Examinat must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1√ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11815 Messick Road 21502 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alvin J. Layman Edith (Golden) Layman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackileen Kaiser daughter 11819 Messick Road Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 8/13/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Cumberland MD21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a/Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, check, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heart Failure ongestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month 5 ☐ Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ eumonia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed?
Yes 2 No 1 Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 28d. Describe how injury occurred 1 Natural 5 Pending efter death. 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e Medical Example 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On/the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

AUG 1 8 2004

Vik Poonai M.D.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Personal Signature & Sports

924 Seton Drive Cumberland, Maryland 21502

D36766

10, 2000

		-	For State Registrar	State	of Marylan		artment of H				giene Reg. No.	004	25	960
	Dhysisi		1. Decedent's Name (First, Middle	e, Last)						Date of De Month	Day		ar	of Death
	Physicia /Medic	al	Clareatha Harr							u1y	25,	2004		05 A M
	Examin	er	4a. Facility Name (If not institution	n, give street and no	umber)		4b. City, Town, or Rockvil	_	of Death			County of D		
			Casey House 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs. 8, p	Date of Bin			Birthplace (State	e or Foreian
	Funeral Director		228-96-5130	1 ☐ M 2 🔏 F		.4 Yrs.	Months Days	Hours	Min. (Month, Da $ept\ 1$	y, Year)		Country) irginia	
			Usual Residence of Decedent							.1				
	ahow dat	_	10a. State 10b. County		10c. City	y, Town or Lo	ocation							City Limits es 2 ☐ No
	Ba-f s	Director	Maryland Montgo	mery	Gai	thers					10- 0:4:			
	with th	D L	10e. Street and Number	Dood			10f. Zip Code 20886				USA	zen of Whai	Country	
	eath is 23	erai	19427 Transhire		cedent Ever in U.	S. 13.		ispanic Ori	igin? (Specify			4. Race - A	merican Indian,	
10	r Iten	Funerai	1 X Never Married 2 Marr	Armed F ied 1 ☐ Yes	orces? 2 X No		Was Decedent of Hi If Yes, specify Cuba			n, etc.)	1	Black, W		
21215-0036	within 72 hours after death with the Maryland ene. Than "netural", or liems 23a or 28a-f show the Medical Examiner mout be notified at	ρ	3 Widowed 4 Divorced	If Yes, G Year or	ive Dates:		1 ☐ Yes 2 🗓 No	Specify:				Specify: B	lack	
5-0	72 ho	Completed	15. Deceden (Specify only highe	l's Education st grade completed)	(Give	denl's Usual Occupa	during mos	t of working		16b. Kir	nd of Busine	ss/Industry	
121	vithin ne. han	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)	Caret	DO NOT use retired	")			шоз	1thcar	ro	
N	filed v Hygie other t		12 17. Father's Name (First, Middle,	Last)		Carei	aker	18. Mothe	er's Name (Fir	st, Middle,				
an	d be sental	To Be	Frank Harris Si					Este	11e Rai	ndal1				
Maryland	should be I tod Mental I s marked o umatic ave	-	19a. Informant's Name/Relations				ng Address (Street							
	allth a		LaDawn N. Harra	is/daught	er	14200) Farnswor	rth L	ane #40	05 Up	per	Marlbo	oro, MD	20772
ore	of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 【Cremation	3 DRemoval from		lace of Dispo emetery, cre	osition (Name of matory or other place	е)	July ^{Da} 2				or Town, Slate	
Ĕ	Pag ment ent: I		' 4 □ Donation 5 □ Other (S	pecify)	W.		el Cremato		2004				larylan	
Baltimore,	permit. Pages 1 a Department of Hes Importent: If Item any injury or othe		21. Signature of Funeral Service Swelly L	Hautt	5 MO12	V /	Name and Address ing Home						lle, MD	21029
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not en	ter the mode of dyin	g, such as	cardiac or res	spiratory a	rrest,		Approxim Interval E Onset an	nate Between
	Physician		Immediate Cause (Final disease or condition	_ a. Meta	static E	reast	Cancer						Oriset ui	o Doatti
	/Medical Examiner		resulting in dealh)	Due to	o (or as a conseq	uence of):								
		_	Sequentially list conditions,	b. — Due to	o for as a consec	uence of								
	ned Insit	nin.	Sequentially list conditions, in any, reading to initios at cause. Enter Underlying Cause (Disease or injury	<		,								
Ć,	be executed sician end burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to	o (or as a conseq	uence of):								
8760,	law requires that the death certificate be executed as been signed by the attending physician end 2 should be detached for use as the burial-transit			d						_				
9	rtifica ng ph	Med	IF FEMALE:	1						- 5.59/11				
Вох	leath certifica attending ph	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 ☐ Feta	I death 3[Ectopic pregnancy				2	3d. Date of Month	delivery Day	Year
O.	the a	Physician/Medical	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐Preg 9☐ Unk	gnant at time of d nown	eath 5[Other (specify)							
σ.	res that the de igned by the a be detached t	Ph	Part II. Other significant conditi	ons contributing to	death but not res	ulting in the u	inderlying cause give	en in Part I	l.	23e. Did t	tobacco u	se contribute	e to the cause of	of death?
Records,	uires sign Id be	d by								1 🗆 '	Yes 2	X No 3□	Probably 4	□Unknown
CO	as been si 2 should I	Completed								24a. Was		24b. Were	autopsy finding	gs available
Re	o - e	mo								autor perfo 1 Yes	psy ormed? 2 ½ No	death	to completion o i? 'es 2□ No	r cause or
Vital	certificate	0	25. Was case referred to medica	1				26. Place	e of Death (Ch					
of V	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2X No			ER/Outpatie							pecifyhosp:	ice
D C	ding Pi		27. Manner of Death 1 X Natural 5 □ Pendi	18.40	e of Injury onth, Day Year)	28b. Time of Injury	Wor	y at k?		Describe	how injury	occurred		
Sio	Attending r death. ector: After by the fune	icat	3 ☐ Suicide 6 ☐ Could		on of loiung - At h	ome farm et	M 1 []	Yes 2		Location /	Street and	d Number or	Rural Route N	umher
Division	after Direct In by	Certification:	4 Homicide determ	nined buil	ding, etc. (Specil	y)	reet, factory, office			City or To	wn, State)			
	spite nours neral						th occurred at the tin							
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical one)		basis of examina inner stated.	ition and/or ir	ivestigation, in my o	pinion, dea	ath occurred a	t the time,	date and	place, and o	due to the cause	e(s)
	To the composite to the	Σ	29b. Signature and title of ceptific	nelly			29c. Licens	e number	115/		29d. Date	e signed (Ma	onth, Pay, Year)
(Alla	ME			- Dr	120	278		+	125	104	
(7	200		30. Name and address of person Charles Harris					Rock	ville	MD 2	0855			
	Str	ate	31. Date filed (Month, Day, Year	32	Agistrar's Signa	ature		LOCK	,					
	Regist		JUL 2	7 2004	Home .	K A	berli							

KENNETH L. HENDRICKS 04-05104 Unpend item # 23a, 27, 28a-f per MR C835, 9/9/04 TT State of Maryland / Department of Health and Mental Hygiene RKD Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST **Physician** 2004 9:15A. Kenneth Lee Hendricks 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner RIVER ROAD & HILLTOP ROAD BALTIMORE CATONSVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 □ F Yrs 39 Director 217-90-8349 March 6, 1965 Mary1and Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. Count or 28a-f show other treumatic event, the Medical Examiner; sust be notified at 1 Yes 2 No Director Sussex ·Seaford Delaware 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 12993 Fleetwood Pond Road 19973 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "neturel", or items 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene.
Is marked other then "neturel", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 disabled n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be of Health and Ments I tem 27 is marked Patricia L. Walls Shields George H. Hendricks ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12993 Fleetwood Pond RD Seaford, DE 19973 Patricia L. Shields/ mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Important: If Ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery Aug 10, 04 Greensboro, Maryland 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home PA PO Box 160 Greensboro, MD 21639 Le 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Drowning associated with Cocaine Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day ō Month Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown sate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate Yes Yes 2 \(\text{No.} 2 No Division of Vital Physicien: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 No this 28a. Date of Injury **Found** Day **8/6/04** 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Attending Found 8:30 a 1 Natural 5 Pending death. 1 ☐ Yes 2 ☑ No Unknown investigation 2 Accident after death Director: 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify)

Found in body of water

28f. Location (Street and Number or Rural Route Number, City or Town, State)

River Rd. and Hilltop Rd.

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 6 Could not be determined 3 Suicide filled in by 4 | Homicide To the Hospitel or A within 24 hours after To the Funeral Direc completely filled in by 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MW O.C.M.E. AUGUST 7,2004 unte 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 1 7 2004

1AMBOUTS

32. Registrar's Signature

LORETO

& Sporks

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vaar **Physician** 2004 DL 28 Hortense E. Irvine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Funeral Months Hours 1 ☐ M 2 🕱 F Director 96 July 6, 1908 Virginia 231-38-0840 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Itam 27 is marked other than "naturel", or items 23a or 28e-f show other treumstic event, the Medical Examinar must be notified at 1X Yes 2 □ No Maryland Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 4403 Dery Road United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ♥ Widowed 4 Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Y. Sledd Fannie Coleman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean I. Holmes-Daughter 4403 Dery Rd., Upper Marlboro, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 0 1 Surial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) ō Forest Hill Cemetery | 8/1/2004 Lynchburg, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home (ewon 4001 Benning Rd., N.E. Wash., DC 20019 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acptylococco **Physician** doto disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed the burial-transit Exami Due to (or as a consequence of): Box 68760, physician Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? =120 Edw 2 24a. Was an page 2 s autopsy 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient Ē P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation s after dea... rel Director: Aftr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai completely within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2250 MS 0 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) wordlow 12 on H. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 2 2004 Registrar

			For State Registrar	State of	Marylan		artment o			nd M	lental Hyg	giene Reg. No2	004	25963
	Diversitati		1. Decedent's Name (First, Middle, La.	st)							2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Harry Delbert				<u> </u>				July 2	8, 20	004	5:55 A M
	Examin	er	4a. Facility Name (If not institution, give Heritage Harbour				4b. City, Tow		Location o: Olis	f Death			ounty of Deat ine Ari	
	Francis				7. Age (In yrs.	last birthday)	If Under 1 Y	ear	If Under 2		8. Date of Birth	1		hplace (State or Foreign untry)
	Funeral Director		484-05-2029	ex. ZM 2□F	89	Yrs.	Months Da	ays	Hours	Min.	7-31-1	914		owa.
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	Aaryla f sho	៦	Maryland Anne A	വാർപ്പ			Annapol	ic						1 □ Yes 2 🛣 No
	the h	rect	10e. Street and Number	uidei			10f. Zip Co					10g. Citize	n of What Co	untry?
	h with	a Di	2515 Painter Cour	ct			2	2140)1				USA	
	ems ?	Funeral Director	11. Marital Status	12. Was Dece Armed For	dent Ever in U.	S. 13.	Was Decedent	t of His Cubar	spanic Orig	in? (Spe Puerto	ecify Yes or No- Rican, etc.)	14	Race - Ame Black, White	
36	s afte	y Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Giv Year or Da	8		1 □ Yes 2 🔀	(No	Specify:			S	pecify: Wh	nite
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other then "netural", or Items 23e or 28e-f show event, the Medical Event activities at	Completed by	15. Decedent's E	ducation		16a. Dece	dent's Usual O)ccupa	tion			16b. Kind	of Business/	Industry
215	within 73 ene. then "n	ple	(Specify only highest gra	College (1	-4or 5+)	life.	kind of work d DO NOT use re	etired)	u <i>ring</i> most	of worki	ng			
21	e filed within al Hygiene. other then ' vent, the Me	Con	12th			Fire	fighter		40 14-4-	4 - N	/P** A B 4 d d d		ic Saf	ety
Maryland	2 should be fill and Mental H Is marked ott	To Be	17. Father's Name (First, Middle, Last, Amos D. Ingi						18. MOTHE		a (First, Middle, a M. Ta		Imame)	
lar	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		19a. Informant's Name/Relationship (al Route Numbe			
	D = 1 = 0		Vivian L. Ingram, 20a. Method of Disposition	Wife	20b. F						apolis,		land 2	
nor	ages int of the		1 ☐ Burial 2 ☒ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		State	_	osition (Name of matory or other cemator			7–29	_04		water,	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		21. Signate of Funeral Service Licer		Tu									eral Home
ñ	Depai Impo eny ir		> funt Viller	0)										MD 21037
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that ca	aused the deat ach line.	h. Do not ent		_	, such as o	_	or respiratory are	rest,		Approximate Interval Between Onset and Death 2 WOS.
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	À	er	Sequentially list conditions, it any, leading to immediate	b. Due to (or as a conseq	dance of).								
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<u>α</u>	that the		Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying caus	se give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rds	w requires been sign should be	ed by									18	es 2 🗆 l	No 3□Pr	obably 4 Unknown
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H	The ate h page	Com									perfor		death? 1 ☐ Yes	
Vital	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Chack only or			
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ion	Attending I or death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Mont	h, Day Year)	Injury	М	Work	? ′es 2 □ h					
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•	To the within 2 To the complet	Me	29b. Signature and tine of certifier	uil)	w		29c. Li	icense	number 198	38		29d. Date s	signed (Monti	n, Day, Year) O U
			30. Name and ad ress of person who	completed caus	e of death (Iter	m 23a) (Type,	Print) B	est	gate	e R	d. A	una	polis,	04 Wd 21401
1	Sta Regist		31. Date filed (Month, Day, Year)	004	egistrar's Signa	ture 6								

			For State Registrar	State of Mary		artment of rtificate of		l Mental Hygie	ene 200	4 25961
5 /	nysicia Medic xamin	in al	1. Decedent's Name (First, Middle, Last, Joseph Johns 4a. Facility Name (If not institution, give PRINCE GEORGE'S H	street and number)			or Location of De	ath	PRINCE (
	neral ector		5. Social Security Number 6. Se.		n yrs. last birthday) Yrs.	If Under 1 Yea Months Day:			(ear) 9. Bir 1923 Sou	thplace (State or Foreign ountry) th Carolina
17215-0036 within 72 hours after death with the Maryland ene.	t be nutified at	Funeral Director	10a. State 10b. County MD Prince G 10e. Street and Number 7814 Beech Nut Ro	eorge's	c. City, Town or Lo	tal Heig		100	g. Citizen of What Co	10d. Inside City Limits 1 ∰Yes 2 ☐ No puntry?
0036 nours after death	I Examiner mus	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 N	o Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc. Black
ified within 72 the Hygiene.	the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occi kind of work don DO NOT use retii	e during most of v	vorking	Private	/Industry
Maryland 21215-0036 d 2 should be filed within 72 hours af the and Mental Hygiens, then the state of the stat	imatic svent	To Be (17. Father's Name (First, Middle, Last) Unknown 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Stree	Unkn	lame (First, Middle, Ma LOWII Rural Route Number, (Zip Code)
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.	any injury or other trau		Edna Johnson/Wife 20a. Method of Disposition 1 Burial 2 **Cremation 3 F '4 Donation 5 Other (Specify) 21. Signature F eral S, vice License	Removal from State	20b. Place of Dispo cemetery, crea Riverdal	osition (Name of matory or other p	ory 7/2		oc.Location - City or verdale, 1	Maryland
Phys	ician dical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	death. Do not en	ter the mode of dy	ring, such as card	d Landover:	t, ,	Approximate Interval Between Onset and Death
8 / 60, sate be executed	the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
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ords, P	should be deta	by	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	inderlying cause ç	given in Part I.			the cause of death?
	ns cermicate nas be I director, page 2 sh	Completed	25. Was case referred to medical				GC Blace of F	24a. Was an autopsy performe 1 Yes 25	prior to	utopsy findings available completion of cause of
	irect	To Be	examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA	Mac	Home 5 Residen	e 6 □Other /Soe	city)
0 = =	= ল		27. Manner of Death Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	of 28c. In		28d. Describe how		347)
Hospital or Att	filled in by t	Il Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S sician: To the best of m	Specify)			City or Town,		
DIVISION To the Hospital or Attending I within 24 hours after death	to the Funeral Director. Aller in completely filled in by the funeral	Medical	(Check only one) 29b. Signature and title of certifier	ner: On the basis of ex and manner stated	amination and/or in	ivestigation, in my	r opinion, death or	courred at the time, date	and place, and due	to the cause(s)
O.A.	(A)	and the same	30. Name and address of person who co	Depo	(Item 23a) (Type,	Print)	8667	1	My 21,	2004
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's	Signature	ble H	:11 67.6	utherville	, MI)	21095

			1 - For State Registrar	State of Maryla	•	artment of F ctificate of			ene g. No. 2 N N	l. oroce
	Physici /Medi		1. Decedent's Name (First, Middle, Last) $Bernice$		Jones			2. Date of Death Month		
	Examir		4a. Fecility Name (If not institution, give s Calvert Memori	al Hospita	1		Frede	rick	4c. County of C	
	Funeral Director		5. Social Security Number 216-40-9039	W -W-	87 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		, 1917 M	Birthplace (State or Foreign Country) [aryland
	e Maryland a-f show illied at	ctor	10a. State 10b. County Maryland Calv		ity, Town or Lo		usby			10d. Inside City Limits 1 ☐ Yes 2 No
	th with th	ai Directo	10e. Street and Number 720 Coster R	oad		10f. Zip Code	0657	10	g. Citizen of What USA	•
036	should be filed within 72 hours after death with the Maryland ud Mental Hygiene. "marked other than "natural", or flems 23a or 28a-f show matte event, tha Medical Examinet must be inclified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Awidowed 4 Divorced	2. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H i Yes, specify Cuba Yes 2 No	lispanic Origin? an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		omerican Indian, /hite, etc. $31ack$
Maryland 21215-0036	within 72 ho iene. than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	ent's Usual Occup kind of work done OO NOT use retired OUSEWif	during most of w d)	orking 16	Own H	
land	\$ g g g	To Be C	17. Father's Name (First, Middle, Last) Henry	Jef:	ferson			ie		
	ith ar lith ar 27 Is 1 Irau		19a. Informant's Name/Relationship (Type Dorisa Jones/Da	, ,		g Address (Street Box 44		Sby, MD	City or Town, State 20657	e, Zip Code)
Š	m O - L		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispos cemetery, crem atuxen	iatory or other plac	em. 7/2		oc. Location - City Hunting	or Town, State
Balt Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service License **Dladyp. G. **	Swell	14 Pr	51 Dare	ss of Facility S s Beac ederic	ewell Fur h Rd. k. MD 200	neral H 678	ome
	hysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	934	or the mode of dyin		Seas		Approximate Interval Between Onset and Death
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r Vital	2 v = 1	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatient	3□ DOA Othe		ath <i>(Check only one)</i> Home 5 ☐ Residend	e 6 □Other (S	nec/fv)
_	tte.	ertification;	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		Sounyy
UNISION	within 24 hours after death. To the Funeral Director: A completely filled in by the tu	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	(y)			City or Town, S	State)	Rural Route Number,
	n 24 horner	edical	29a. Certifier 1. Certifying Physi (Check only one) 1. Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inve	occurred at the time estigation, in my op	e, date and plac pinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
1	withi To th	ž	29b. Signature and title of certifier	h		29c. License			Date signed (Mo	
,	Q		30. Name and address of person who com	0 1 1	-	rint)	1 50	202	P	04, Frederick,
	Sta Registr		31. Date filed (Month, Day, Year) JUL 2.3	32. Registra s Signa		Anail :	1 300	w 3.7	JAM CE	, ruewen,

			For State Registrar	State o	f Marylar		artmen			and M	lental Hy	giene	001	25067
		4	Decedent's Name (First, Middle, La	st)							2. Date of De	ath (. U U Y	3. Time of Death
	Physici /Medic	~	Elmer Jac	ks							July :	25 2	004 Year	11:32 Ma
	Examin	_	4a. Fecility Name (If not institution, give		mber)		4b. City,	Town, or	Location of	of Death		4c.	County of Death	ר
			Prince George'	s Hosp	ital		Chev					Pr	ince G	eorge's
	Funeral			Sex NgM 2□F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Big (Month, Da Feb.	th y, Year)	Col	nplace (State or Foreign untry)
ÇL.	Director		213-42-9694	JE W ZUT	60	Yrs.					Feb.	9 19	44 Mar	yland
	pur *	}	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Aaryl reho	ō,	for a second	0.000	- 1		Ma and	h = 10 1	_					1 ☐ Yes 2 ☐ No
	the t	Directo	Maryland Prince 10e. Street and Number	Georg	e 5 0	pper	10f. Zip					10a. Citi.	zen of What Coi	untry?
	Sa or		11332 Drumsheu	ch Tan	0			0774	Ą				USA	•
	Heath The 2:	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	cify Yes or No)-	14. Race - Amer	
က	or He	Fur	1 Never Married 2 Married	Armed Fo	2 No					, Puerto	Rican, etc.)		Black, White	o, etc. Black
වී	rait, o	by	3 Widowed 4 Divorced	If Yes, Gr Year or D	ve ates:		1 ☐ Yes	2 LANO	Specify:				Specify:	Lack
Maryland 21215-0036	72 hours after death with the Maryland Instural', or Items 23a or 28a-f ehow digal Examiner must be rediffed at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	dent's Usua kind of wor	k done d	turina mos	t of worki	ng	16b. Kii	nd of Business/I	ndustry
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2	ygier th		12th	0		S	uper	vis			/PT - A #1 4 4		itatio	n
and	be fi	Be	17. Father's Name (First, Middle, Last	,							(First, Middle		Surname)	
2	1 Mer nark	T _o	Wesley Jacks	Cinn a Daine		105 14-16		/Ct1			Curt		T C1-1- 7	7. 0. 4.1
Mai	12 st h and 7 is n traun		19a. Informant's Name/Relationship											ip Code) 20774
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other then "naturat", or items 23a or 28a-f show any highry or other traumatic event, Ita Medical Examinational be notified at ance.		Shirley Jacks 20a. Method of Disposition	(MTIS)	20b. F	Place of Dispo			sueu		Date	14	cation - City or 1	
20	ages nt of nt of		Burial 2 □Cremation 3 □		State	emetery, crei IOSES	matory or o	ther plac		7/31	104		ry, Md	
Baltimore,	it. Purtue		*4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		P.		2. Name an		-		/ 0-2	DIG	. L y / 110.	•
Ba	Depa Impo any ir		1-1 44	2	20018	2 W	m. R	ees	e & :	Sons	Mort	uary	P.A.	
			23a. Part1. Enter the disease, or con-	plications that	aused the deat	h. Do not ent	21 W	est e of dyin	St. g, such as	Ann cardiac o	a poli	rrest.	d. 214	Approximate
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Socuentially in conditions if any, leading to immediate	a. CONO Due to b. HYPE	(or as a consec RIEWS	uence of):	ART	FAI	LURE	-				Interval Between Onset and Death
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P.O.	that the de ed by the detached	lysi	1 Yes 2 No 9 Unknown	9□ Unkn	own									
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00	aw requir ss been si 2 should	Completed									24a. Was		24b. Were aut	opsy findings available
Re	0 = 0	E										rmed?	death?	ompletion of cause of
tal	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2 No	1 1 105	2 NO
<u> </u>	SOF	OB	examiner? 1 ☐ Yes 2 👿 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe					Other (Spec	ifv)
o	g Ph er thi	ı; T	27. Manner of Death	28a. Date		28b. Time o	f 2	8c. Injury Work			28d. Describe			
Ö	Attending in death.	atio	1 Natural 5 Pending 2 Accident investigation	n .	in, buy rous	injury	М		Yes 2□	No				
Division	o it c	Certification:	3 Suicide 6 Could not to determined	286. Place	of Injury - At h ing, etc. <i>(Specil</i>		reet, factory	, office		2	28f. Location (City or To			ral Route Number,
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	To the within 2 To the complet	Σ	29b. Signature and title of certifier		-			_	number				signed (Month	7 1 1 1 2 1
			OW Brokell	Guer	sar	MO		D5	3209	7		1	1-25-1	of
			30. Name and address of person who		se of death (Iter		Print)		7 -		,)		04 D 20185
			WENDELL RIERSE		, 3		OSFIT.	AL	DRI	E	C	HEVE	RLY, M	0 20185
	Sta	ite	31. Date filed (Month, Day, Year)	004	legistrar's Signa	ture	mall o						/	

		1	For State Registrar	State of Marylan		artment of H			jiene 1eg. Noc2 () () (25968
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Yea	3. Time of Death
	Physicia /Medic	_	John Ber	nard Jamison				August	8 2004	. 14
	Examin		4a. Facility Name (If not institution, give s	treet and number)			r Location of Deat	h	4c. County of D	eath
Н	3	-34/1	Union Hospital 5. Social Security Number 6. Sex	7. Age (In yrs.	last hirthday)	Elktor	∩ If Under 24 Hrs	8. Date of Birth	Cecil	Birthplace (State or Foreign
	Funeral Director			M 2□F 69	Yrs.	Months Days	Hours Min.		(Year)	Country) Maryland
7	9	-	Usuel Residence of Decedent							
	show		10a. State 10b. County		ty, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f	Director	Maryland Cecil 10e. Street and Number	E	Elkton	10f. Zip Code			10g. Citizen of Whal	
	Milh I		12 Doe Drive			21921			United	
	19 23	Funeral		2. Was Decedent Ever in U Armed Forces? 195	S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-		merican Indian,
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with rine maryland Department of Heatih and Mental Hygiene. Departments if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exeminer martice natified at once.		1 ☐ Never Married 2 X Married	1 X Yes 2 No If Yes, Give 196		1 ☐ Yes 2 ☒ No	Specify:	to rican, etc.)	Specify:	
3-003e	tural',	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occur	ation		16b. Kind of Busine	White
ဂ်	n nel	Completed	(Specify only highest grade		(Give	kind of work done DO NOT use retired	during most of wo	rking	Tob. Tang of booms	,
7	d within giene. er than	mo.	8	College (1-401 3+)	Or	derly			Health	Care
and	be filed tal Hygie d other event, ti	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		
ya	should to the marker than the	ို	Dorian Dale Jamis		405 14-11	Add /Casas		n Simmons	r, City or Town, State	Tin Code)
	d 2 sh th and 7 Is n traun		19a. Informant's Name/Relationship (Ty) Ruth L. Jamison/W			Doe Drive				e, 21p 000e/
<u>ရ</u>	tam 27		20a. Method of Disposition	20b. I	Place of Dispo	osition (Name of matory or other place		Date 12,	20c. Location - City	or Town, State
E	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cemetery			Port Depo Maryland	osit,
	permit. Departm Importa any inju		21. Signature of Funeral Service License	ое] _	2	2. Name and Addre	ess of Facility	nerals, F		
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Re	The lav te has age 2	Completed	Thravit Ob	Lixtuol	Culma	2001/1	Diseas	autop perfor 1 Yes	rmed? _ death	to completion of cause of 1? /es 2 No
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>	Physician: The la r this certificate haviral director, page 2	10	1 Tes 2 No	lospital: 1 ☐ Inpatient 2	R/Outpatre	IN SEL DOA			lence 6 Other (5	Specify)
o no	ding P h. After t funera	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 ⊡No	28d. Describe h	low injury occurred	
Division of	i or Attending Physician: after death. Dirsctor: After this certification by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I	nome, farm, si		1165 2 110	28f. Location (S	Street and Number of	Rural Route Number,
<u>S</u>	a High	Serti	4 Homicide	building, etc. (Speci	ify)			City or Tow	m, State)	
	ospite hours unera unera			sicien: To the best of my kn ner: On the basis of examin						
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner stated.		29c. Licen:			29d. Date signed (M	
-	or Note	-	29b. Signature and title of certifier		/ 4.	290. Licens	3 () /	/	250. Date signed (M	1/1 /14
	NU		30. Name and address of person who co	maleteri cause of death lite	M 23a) (Tune	Print)	237/3		0 /	
	D1.		Barbara A. Parey,	/			Suite 2	14, Elkto	on, Maryla	and 21921
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		souls				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Michael 11:50 am February 2004 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner University of Marylans Medical Baltimore ente If Under 1 Year | If Under 24 Hrs. 8. Date of Birth /Month, Dey 5. Social Security Number Sex 1 M 2 F 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Director Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner must be notified at NIA 1 ☐ Yes 2 ☐ No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours efter death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U,S Armed Forces? Race - American Indian, Black, White, etc. 11. Meritel Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 2 Married 1 ☐ Never Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 D No Specity: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Depertment of Health end Mentel Hygi important: If Item 27 is marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be ohnsor QY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Pelationship (Type, Print) 5608 Broadmoor Terrale Johnson/Fath Johnamsville Maryland 21454 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - Oity or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 DOther (Specify) Tucket 15/04 Manyld Hosp 21. Signature of Funeral Service Licenses 2. Name and Address of Fecility 2250 / Green St Balting Del 2/1201 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner at 19 weeks gestation Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last attending physician end Division of Vital Records, P.O. Box 68760, were Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be deteched to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 232No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3□ DOA 27. Menner of Death 1 Matural 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No efter death. 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 - Homicide within 24 hours e the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 30. Name and person who expleted cause of deeth (Item 23e) (Type, Print) reene St, BAlto, Md MO Kighty

Registrar **DHMH 16 Rev 6/95**

State

32. Register's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day 2004 **Physician** 1 10:26AM William Joseph Kimmel August /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Washington Julia Manor Nursing Center Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 07/10/1922 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days Hours 12XM 2□ F Yrs 82 579-16-4038 Director DC Usuel Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits r than "naturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director MD Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5 Princeton Place 21742 USA permit. Pages 1 and 2 should be filed within 72 hours after dea: Department of Health and Mantal Hygiena. Important: if item 27 is marked other than "naturel" or Hammalta event and injury or other treumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1942-45 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Foreman Utility 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Schott William Kimmel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph I. Kimmel / Son 12 Letterman Court, Gaithersburg, MD 20878 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 08/05/04 Silver Spring, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Medicul Renal Examiner Due to (or es a consequence of): Examine 251 To the Hospital or Attending Physician: The law requires that the death certificate be executed inding physiclan and usa as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this i Director: After this ad in by the funeral of 28a. Date of Injury (Month, Dey Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pendina death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D completaly filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no060396 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 1126 OPAL COURT HAGERSTOWN MD 021740 RSHED ARID M 31. Date filed (Month State

DHMH 16 Rev 6/95

Registrar

				For 1 = State	State of M	-	Department Certificate					1	00071	
				Registrar 1. Decedent's Name (First, Middle, L	ast)		Ochimoato	OI Dea		2. Date of Dea	teg. No.	14	3. Time of Death	_
_	н	Physici		Khaiasteh	Key	hani				Month Tulv	Day	Year LOO4	6:26 pm	A
		/Medic Examir		4a. Facility Name (If not institution, g.	ive street and number)		4b. City, T	own, or Location	on of Death		4c. County			
				Suburban Hospita	1		Reth	esda			Monta	nma ***	· Co	
		Funeral		Social Security Number 6.	Sex 7. Ag 1 ☐ M 2 2 F	ge (In yrs. last bir	Months	Year If Und Days Hou	der 24 Hrs. rs Min.	8. Date of Birtl (Month, Day	, Year)	9. Birthp	lace (State or Foreign try)	n
		Director		219-98-6933 Usual Residence of Decedent	2/81	87	Yrs.		ناــــان	anuary 1		Iran		_
		land		10a. State 10b. County		10c. City, Tow	n or Location					1	Od. Inside City Limits	-
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		th the Marylan or 28a-f show	Director	10e. Street and Number	ely	Decine	10f. Zip (Code			10g. Citizen of V	Vhat Coun		
		23a o		7401 Westlake Te	rrace #41	1	207	1.8			U.S.A.			
		ltems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decede		Origin? (Specican, Puerto R	cify Yes or No-	14. Rac	e - Americ k, White,	an Indian,	
	36	rs after death with I', or Items 23a or	by Fu	1 Never Married 2 Married	1 □Yes 2 🔀 If Yes, Give		1 ☐ Yes 2			, ,	Specify			
	5-0036	3 6 W		3 ☑ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	160	Decedent's Hevel	Ossumation				AATIT		
	5	in 72 ho "natur	Completed	(Specify only highest g	rade completed)		. Decedent's Usual (Give kind of work life. DO NOT use	done durina n	nost of workin	g	16b. Kind of Bu	isiness/ind	dustry	
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	<u>lar</u>	should be and Mental is marked c	To B	Ali Kevhani				Fal	lchrolm	nolook	Aliabad	;		
	Maryland	0 0 00		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Address						Code)	
		C - C4 F		Faranak Sotoudeh (Daughter-In-L		918 Bren	t Rd.,		c, MD_	20854			
	Baltimore,	S to the		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3	☐Removal from State	comoto	f Disposition (Namery, crematory or other	e of ner place)	Da	ate	20c. Location -	City or To	wn, State	
	Ë	permit. Page Department of Important: If any injury or once.		\ 4 □Donation 5 □ Other (Spec	city)		al Memorial	Park	7/28/0	4	Falls C	nurch	. VA	
	3al	Separ Mpor mpor iny in		2). Signature of Funeral Service Lic	ensee		22. Name and	Address of Fa	acility Murp	hy Fal	ls Chur	ch Fu	neral Home	е
		40264		James)	1. Their	d Aboutouth Do	1102 W.	Broad	Street	, Fall	s Church	ı, VA	22046 Approximate	
				23a. Part1. Enter the disease, or co- shock, or heart failure. List on	y he cause on each li	ine.	not enter the mode	or dying, such	as cardiac or	respiratory an	rest,		Interval Between Onset and Death	
		Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Conge	stive	Heart,	Failur	e			- 1		
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12.6			ē	Sequentially list conditions, if any, leading to immediate		a consequence	of):					_		
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5	oʻ	exec an an		resulting in death) Last	Due to (or as	a consequence	of):							
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3	9	ng ph	Med	IF FEMALE:										
~	Вох	leath certifica attending ph	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 □Ectopic pre	gnancy				e of delive	•	
EH	O. E	ne des the al	Sici	1 Yes 2 No	4□Pregnant a 9□Unknown	t time of death	5 Other (spe	cify)			Mo	iui	Day Year	
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	of	<u>a</u> + <u>B</u>	H-	27. Manner of Death	28a. Date of Inju			c. Injury at Work?			ence 6 Other		′)	-
=	ion	nding f ath. r: Atter e tuner	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		ay Year)	Injury M	Work? 1 ☐ Yes 2	No					
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2		To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Attencompletely filled in by the tune	edical	29a. Certifier Check only one) Certifying F	Physician: To the best	of examination ar	e, death occurred a nd/or investigation,	t the time, date n my opinion,	and place, ar death occurre	nd due to the o	ause(s) and ma date and place,	nner as st and due to	ated. the cause(s)	
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		⊢ ≯ ⊢ ŏ		> 2. Hali	rich m.	D		284.			July 2			
	~ A	0 6		30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type, Print)					,		
	UK	(以)		m 1	Hallick,	mo		15 Fernw	ood Rd.,	#100, Be	thesda,Md	. 2081	17	
		Sta		31. Date filed (Month, Day, Year)	_	rar's Signature			•					
		Regist	rar	JUL 3 0 200	14 Marian	. 1 .	mark)							

			1 - For State Registrar	State of Ma	ryland			nt of H te of L			ental Hy	giene Reg. No		250	72
П	Physicia	an	1. Decedent's Name (First, Middle, La	ast)							2. Date of De Month	ath Day	Year	3. Time of	Death-
,	/Medic	al	Ben H. Ki				4. 01.			-4.0	Ju1y	22			РМ
	Examin	er	4a. Facility Name (If not institution, gi				40. Cit	, Town, or C 1 1 -			•	40.	County of Dea		
	Funeral			Sex 7. Age	(In yrs. las	st birthday)		er 1 Year	rer S	24 Hrs.	8. Date of Bir (Month, Da	th	9. Bi	thplace (State o	r Foreign
	Director		241-32-9334	1 X M 2□F	95	Yrs.	Months	Days	Hours	Min.	May 28			ountry) rth Caro	lina
	pg 🙎		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Loca	ation							10d. Inside Ci	by Limite
	sho	5	Maryland Montgo		roc. Oity	TOWN OF EGG	41011	Silv	er S	pring	2			1X Yes	-
	the A 28a-1	Directo	10e. Street and Number	1			10f. Z	ip Code		r		10g. Cit	izen of What C	ountry?	
	filed within 72 hours after death with the Maryland Hygiene. Ather then 'natural', or Items 23e or 28e-f show ant, the Medical Esacinet must be neithed at	i D	2015 East West	: Highway					209	10			United	States	
	ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Dec	edent of Hi	ispanic Or	rigin? (Spe	cify Yes or Ne Rican, etc.)	p-	14. Race - Am Black, Whi		
ဝ	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🌠 No	0			2)(1) No	Specify:					Black	
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7	e filed within al Hygiene. other then 'vent, the Ma	mo	Elementary/Secondary (0-12) 7th	College (1-40r 54	+)			Const	truct	ion			Pri	vate	
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yland	2 should be and Mental Is marked raumatic ev	P.	Ben Ki		r									ittrell	
Mar	es 1 and 2 should b of Health and Ment if item 27 is marked ir other traumatic e		19a. Informant's Name/Relationship Julia White -								Nash.,		r Town, State, 20010	Zip Code)	
e,	1 and Health em 2		20a. Method of Disposition	315661	20b. Pla	ce of Dispos					ate		cation - City o	r Town, State	
TIMOL	permit. Pages Department of I Important: If its any injury or o		†☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec						1	7/29	/2004				
	nit. Partme ortan injur		21. Signature of Furieral Service Lice	<u> </u>	Lac	range		and Addres					LaGran		
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			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused y one cause on each lin	the death.	Do not ente	r the m	ode of dyin	g, such as	cardiac o	or respiratory a	ırrest,		Approximate Interval Bet	мөөп
3	Physician		Immediate Cause (Final disease or condition	_	_	Cancer								Onset and I	Death L T
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):									
	LXummer	-	Sequentially list conditions,	b. Due to (or as a	conseque	nce of):									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0) 03 0	2 00130440	nios oi).									
~	be executed ician and burial-transit	Exal	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):	******								
09/	ate be executed thysician and the burial-transit	ical		d											
30	The law requires that the death certificate the been signed by the attending physoage 2 should be detached for use as the	Med	IF FEMALE:												
P.O. Box	leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal d	death 3⊡l		pregnancy	,				23d. Date of de Month		'ear
O	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of dea	ith 5⊔	Other (specify)						•	
	res that t signed by be detad		Part II. Other significant conditions	contributing to death bu	ut not result	ting in the un	derlying	cause give	en in Part	1.	23e. Did	tobacco	use contribute	to the cause of d	eath?
ds	quires n sign ald be	d by	Demen	tia							10	Yes 2	□No 3□F	robably 4 🗀	Jnknown
ဝွ	aw require s been siy 2 should b	Completed	Anemi	а							24a. Was		24b. Were a	utopsy findings	available
Ä	hysician: The law his certificate has b I director, page 2 s	шо									auto perf 1 🗆 Yes	ormed?	death?	completion of c	ause or
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<u>></u>	Physic this ce al dire	2	1 ☐ Yes 2 No			R/Outpatient	3 🗆 1						6 □Other (Sp	ecify)	
ň	ding P. h. After (funera	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 2	28b. Time of Injury	М	28c. Injun Worl	yat k? Yes 2.⊑		28d. Describe	how inju	y occurred		
Division of Vital Records,	ten leat tor:	licat	2 Accident investigat 3 Suicide 6 Could not	be Geo Place of Inju	ury - At hom	ne. farm. stre			163 2		28f. Location	Street ar	nd Number or F	Rural Route Num	ber.
≧	after Direction by	Certification:	4 Homicide determine	building, etc	. (Specify)		01, 1001	ory, omou			City or To				00.,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the			Physician: To the best of											
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			- College						DZ00				литу 2	2004	
C	2 (1))	30. Name and address of person wh					1270	#/.0/	ir c	ilver S	Snri-	or MD	20910	
	- St	ate	31. Date filed (Month, Day, Year)	assi, M.D.			110 /	ive.,	11 4 0 4	5 G	rrver :	phili	ig, riii	20310	
	Regist		nn 3 0 200	14 Media	K	Acce	61								

			For State Registrar	State of Maryland		nt of Health and ate of Death		iene _{eg. No.} 2004	25070
			Decedent's Name (First, Middle, Las	*1			2. Date of Deat		3. Time of Death
	Physicia	an	1. Decedent s Ivame (First, Middle, Las		11		Month	Day Year	
	/Medic		John S	inclair	Keev	1e	July	30 2004	1129 AM
4	Examin		4a. Facility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Dea	ith J	4c. County of Deat	h
			Dorchester Ge	neral Hospi	tal Co	embridge		Dorch	octer
	Europel		5. Social Security Number 6. Se			ler 1 Year If Under 24 Hr	s. 8. Date of Birth		hplace (State or Foreign
	Funeral			M 20F 72	Yrs. Month:	s Days Hours Mir	S. B. Date of Birth (Month, Day,	7 10 2 1 AA.	untry)
	Director		X17-25-3302	10			Dulyd	1931/10	ryland
	D >	-	Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits
	larylan show	_	Tod. State	ioc. Gity, i	A A A				
	W I	용	MD Dorch	rester	Madis	50n			1 Yes 2 No
1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ē	10e. Street and Number		10f. 7	Zip Code	1	0g. Citizen of What Co	untry?
Y	er death with the Maryland Items 23s or 28s-f show Let must be notified at	Funeral Director	4548 White 1	novel page	-Bex 43	21148		1150	
3	death	ra	10 10 11			21610	0	4577	dan badan
-	r de	=	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	If Yes, s	cedent of Hispanic Origin? (secify Cuban, Mexican, Pue	rto Rican, etc.)	14. Race - Ame Black, White	
ဖွ	afte or II	正	1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 █ / No If Yes, Give	1 □ Yes	2 No Specify:		Specify: a	
8	hours after ural', or Ite	þ	3 Widowed 4 Divorced	Year or Dates:		22.10 0,000.91			ick
5-0036	72 hc	Completed	15. Decedent's Ed	ucation	16a. Decedent's Us	sual Occupation		16b. Kind of Business/	
215	7 11	e	(Specify only highest gra		life. DO NOT	work done during most of w use retired)	orking		
	within ene. than	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)	200000	La Ilma We	Van K	Seafood	Tuductivu
21	e filed within al Hygiene. I other than "		3 5-10-de Nove (5-1-4 Middle 1-1-1)		Loce22	ing Line Wa	ame (First, Middle, I		+Viausi j
2	d of	Be	17. Father's Name (First, Middle, Last)			16. Mother's N	ine (First, Middle, i	walderi Sumame)	•
<u>a</u>	Ment Ment	ပ္	James Si	nclair Lee		Mart	ha H.	Keene	
5	and h	•	19a. Informant's Name/Relationship (ss (Street and Number or F	Rural Route Number		Zip Code)
Maryland	d 2 th a 7 is		Tealvalla Day	etha Keene	4646 111	hito Marash	101 Ray 4	3. Madison	1 MAD 211.48
	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23s or 28e-f show item 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic event, the Medical Evant art must be notified at			20h Pla	4548-W	hite Marsh	Date	20c. Location - City or	Town State
Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	netery, crematory of	outer place)			
Ě	permit. Page Department Important: if any injury or once.		`4 □Donation 5 □ Other (Specify	Ma	lone C	emetery 81	7104	Madison	MD.
Ξ	artin orta		21. Signature of Funeral Service Licen			and Address of Facility		Δ	,
Ba	Department of the partment of		Dans 100.	2/0	Hen	and Address of Facility RY Funeral	Home	i i i aaf	11/12
			- function c	· Cherry	510	Washington	St. Cami	bridge, MI	1.21613
			23a. Part . Enter the disease, or com- shock, or heart failure. List only	dications that caused the death.	Do not enter the m	ode of dying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
	Physician	. 17	Immediate Cause (Final	Find Co			2. 1272510 DO		Onset and Death
4	/Medical		disease or condition resulting in death)	a. End sta	Je 10	onul dis	ccoe		
	Examiner			Due to (or as a conseque	ince oi):				
		L	Sequentially list conditions,	b. Nas	20105				
	n =	ë	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as a conseque	ince of):				
	uter d ansi	Ξ	cause. Enter Underlying Cause (Disease or injury that initiated events	•					
	be executician and burial-trar	Examiner	resulting in death) Last	Due to (or as a conseque	nce of):	· · · · ·			
760	ite be executed ysician and ne burial-transit	cai							
ന	ate the	i c		d					
9	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE:						
Вох	h ce andii use	2	23b. Was decedent pregnant	23c. If yes, outcome of pregnance 1 Live birth 2 Fetel de		-10000000		23d. Date of del	ivery
α	atte	cia.	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of dear				Month	Day Year
o.	t the de by the tached	ysi	9 Unknown	9□ Unknown					
Δ.	d by detac	P.	Part II. Other significant conditions of	antributing to doub but not regult	ting in the underhies	and a superior of the state of	22a Did to	bacco use contribute to	the cause of death?
Ś	res that signed to be det	þ	rait ii. Other significant conditions of	Announcing to death but not result	ing in the underlying	Cause given in Fait i.			\
5	v requir been si should						1 □ Y	es 2⊡No 3⊡Pr	obably 4 Unknown
္ပ	w requ been shoul	et					24a. Was a	n 24h Were au	topsy findings available
ě	e lav	문					autops	y prior to	completion of cause of
<u> </u>	Th ate pag	Completed						2XNo 1 ☐ Yes	2 🗆 No
ita	iclan: Th certificate rector. pag	Be	25. Was case referred to medical			26. Place of D	eath (Check only on	10)	
>	ysic is ce direc	0	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☑ EF	R/Outpatient 3 1	DOA Other: 4 Nursing	Home 5 ☐ Reside	ence 6 Other (Spe	cifu)
ō	Phys this al di	 	27. Manner of Death	28a. Date of Injury 2	28b. Time of			ow injury occurred	ony)
Ë		<u>5</u>	1. Natural 5 ☐ Pending	(Month, Day Year)	Injury M	28c. Injury at Work?		,,	
	ling f		2 Accident investigation		M	1 ☐ Yes 2 ☐ No			
-5	ending feath.	cat	a Cloudelde C Could not b	28e. Place of Injury - At hom	ne, farm, street, fact	ory, office	28f. Location (Si City or Town	treet and Number or Ru n. State)	ural Route Number,
visio	ng I fter iner	tificat	3 Suicide 6 Could not b	building, etc. (Specify)				, ,	
Division of Vital Records,	al or Attending Is after death. I Director: After din by the funer	Sertificat	determined	building, etc. (Specify)			1		
Division	spital or Attending Is ours after death. neral Director: After filled in by the funer	al Certification:	4 Homicide determined	building, etc. (Specify)		ed at the time, date and pla	ce, and due to the c	ause(s) and manner as	stated.
Divisi	Hospital or Attending is a hours after death. Funeral Director: After tely filled in by the funer	lical Certificat	4 Homicide determined 29a. Certifier (Check only 2 Medicel Exer	building, etc. (Specify) ysicien: To the best of my knowled inner: On the basis of examination	rledge, death occurre	ed at the time, date and pla- on, in my opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
Division	the Hospital or Attending in 24 hours after death. the Funeral Director: After npietely filled in by the funer	Aedical Certificat	4 Homicide determined 29a. Certifier (Check only one) Certifying Phase 2 Medicel Exer	building, etc. (Specify) ysicien: To the best of my knowle	rledge, death occurre on and/or investigati	on, in my opinion, death oc	curred at the time, d	ate and place, and due	to the cause(s)
Division	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certificat	4 Homicide determined 29a. Certifier (Check only 2 Medicel Exer	building, etc. (Specify) ysicien: To the best of my knowled inner: On the basis of examination	rledge, death occurre on and/or investigati	ed at the time, date and platon, in my opinion, death oc	curred at the time, d	ause(s) and manner as ate and place, and due	to the cause(s)
Division	Hospital or 4 hours afte Funeral Dir iely filled in l	Medical Certificat	4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) ysicien: To the best of my knowledge of the basis of examination and manner stated.	rledge, death occurre on and/or investigati	on, in my opinion, death oc	curred at the time, d	ate and place, and due	to the cause(s)
Division	To the Hospital or Attending It within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Medical Certificat	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	building, etc. (Specify) ysicien: To the best of my knowledge of the basis of examination and manner stated.	rledge, death occurre on and/or investigati	on, in my opinion, death oc	curred at the time, d	ate and place, and due	to the cause(s)
Division	To the Hospital or Attending It within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certificat	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Name and address of person who	ysicien: To the best of my knowledge. ysicien: To the best of my knowledge. ysicien: To the basis of examination and manner stated. On the basis of examination and manner stated.	eledge, death occurred and/or investigation and/or investigation and/or investigation and a second a second and a second and a second and a second and a second a	on, in my opinion, death oc 29c. License number	curred at the time, d	ate and place, and due	to the cause(s)
Division	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who Michelle F. parso	ysicien: To the best of my knowledge. ysicien: To the best of my knowledge. ysicien: To the best of my knowledge. ysicien: To the best of my knowledge. ysicien: To the best of examination. ysicien: To the best of examination. ysicien: To the best of examination. ysicien: To the best of examination.	eledge, death occurrent and/or investigation and/or	on, in my opinion, death oc 29c. License number	curred at the time, d	ate and place, and due	to the cause(s)
Division	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who Michelle F. parso 31. Date filed (Month, Day, Year)	puilding, etc. (Specify) ysicien: To the best of my knowledge in the passis of examination and manner stated. Owner: On the basis of examination and manner stated. Owner: On the basis of examination and manner stated.	eledge, death occurrent and/or investigation and/or	on, in my opinion, death oc 29c. License number 260055 Cambridge, MD	curred at the time, d	ate and place, and due	to the cause(s)

		,	1 - State Registrar	State of Mary	•	artment of H		•	Reg. No.	25974	
	Physici		1. Decedent's Name (First, Middle, Last) Lawrence C. Kolb	Sr.				Month		3. Time of Death 9:22 A	
>	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of De		4c. County of E		
			Kline Hospice Hou			Mt. Air	<u> </u>		Freder		
İ	Funeral Director		5. Social Security Number 217 28 1054 Usual Residence of Decedent	M 2□ F 7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da August	th y, Year) 6,1931 M	Birthplace (State or Foreign Country) aryland	
	yland pow		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits	
	Marfat	ctor	Maryalnd Frederic	k	Thurmo	ont				1 ☐ Yes 2 XNo	
	or 28	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?	
	s 23a	ral	16128 A Kelbaugh R		- 110	21788	11.00=1-0		United St		
136	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Exartirating the Incillib.d at	by Funeral Directo	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No lerto Rican, etc.)	Black, V	American Indian, White, etc. hite	
Maryland 21215-0036	2 hou	ted	15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ation	wating	16b. Kind of Busin	ess/Industry	
2	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	dunng most of t	working			
2	led will you her the				Supe	rvisor	40.14.15.1.1		Constru	ction	
and	ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Emanuel J. Kolb					Name <i>(First, Middle,</i> ie M. War			
Š	should ind Men marke umatic	2	19a. Informant's Name/Relationship (Type	ne Print)	19b Maili	ng Address (Street)			er, City or Town, Sta	te. Zin Code)	
	and 2 sealth ar n 27 is		Beverley Kolb/ Wi	. ,	1879/25/20	NAME OF THE PARTY			, MO 2178		
ē,	es 1 and 3 of Health fitem 27 ir other tr		20a. Method of Disposition	2	Ob. Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City	y or Town, State	
altimore,	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ny's Cem		ust 5,200	4 Emmits	burg, Maryland	
Balt	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any Injury or other traumatic ODEs.		21. Signature of Funeral Service License	Elen			ss of Facility S	tauffer F	uneral Ho t, Maryla	me	
8760,	/Medical Examine and physician and physician the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):	u'a/				Onset and Death	
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy	,	- 11	23d. Date of delivery Month Day Year		
<u>α</u>	s that ned b e deta	y Pr	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use contribu	te to the cause of death?	
īg	w require been sig should b	ed b	Metastatic	Adena	or the res	oma 1	ung	_ 💢	Yes 2□No 3[Probably 4 Unknown	
al Records,	ysician: The law requisions certificate has been director, page 2 should	Completed					0	1 ☐ Yes	prior deal 2 No 1		
Viita	reicia s certi directo	To Be	25. Was case referred to medical examiner? 1 Yes No H	ospital:	2 ☐ ER/Outpatie	ot 30 DOA Oth	ar	Death (Check only only of Home 5 Resi		Specify) Haspice	
Division of	ing Ph n. After th funeral		27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Ye		of 28c. Injur Wor			how injury occurred	HOUSE	
Divis	tal or Atters as after de al Diracto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, st Specify)	reet, factory, office		28f. Location (City or To		or Rural Route Number,	
	To the Hospital or Attendwithin 24 hours after death To the Funeral Director:	edical	29a. Certifier (Check only one) Certifying Physical Examination	icien: To the best of m ner: On the basis of exa and manner stated.	amination and/or ir	th occurred at the tin estigation, in my o	ne, date and pla pinion, death o	ace, and due to the ccurred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
	To the within 7 To the comple	Σ	29b. Signature and title of certifier	C .	•	29c. Licens			29d. Date signed (A		
	. 1		JAN .	Shah t		D576	43		August 2	., 2004	
7	5+1		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,		. 0	mp o	JIZOS		
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1 6		mp 6	M702		
	Regist		AUG 0 3	2004 > 54	mera /	10	all	`			

	E
Division of Vital Records, P.O. Box 68760,	Mosnites or Attending Physician: The law requires that the death certificate he executed
	- 4

			State of Maryland / Department of		-		
			Certificate of	f Death	Re	g. No. 2 0 1 L	25975
	Physicia		1. Decedant's Nama (First, Middla, Last) Margaret A. Kincheloe		2. Date of Death July 31	Day Vee	3. Tima of Death 4:45 PM
	/Medic Examin		4a Facility Nama (If not institution, giva street and number)	4b. City, Town, or L	ocation of Daath	4c. County of Death	
			Sacred Heart Home	Hyatts			George's
	Funeral Director		5. Social Security Number 226-10-6440 6. Sax 1 Months 1 Mark 22KF 91 Yrs. 6. Sax 91 Months Day:		8. Data of Birth (Month, Day, Dec 20,	Year) 9. Birth Cou 1912 Vi	place (Stata or Foraign htry) rginia
	show thow		Usual Rasidance of Dacedent 10a. Stata 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yas 2 □ No
	M M	Director		arrollton	40	Chiese of Miles Co	
	death with the Meryland rms 23e or 28e-f show rmust be notified at		10e. Street and Number 6400 86th Avenue 10f. Zip Coda 2	0784	10	g. Citizen of What Cou USA	
	daat	Funeral	11. Marital Status 12. Was Dacedant Evar in U,S. 13. Was Decedent of Armed Forcas? 13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Maxican, Puarto	ecify Yas or No- Rican, atc.)	14. Race - Amari Black, Whita	
020	72 hours efter death with the Marylan naturel', or frems 23a or 28a-f show pical Examiner must be notified at	þ	1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 ☒ No If Yes, Give 1 ☐ Yas 2 ☒ No Yaar or Dates:			Specify: Wh	ite
		Completed	15. Decedant's Education (Spacify only highast grada complatad) (Giva kind of work down life. DO NOT usa retir	upation e during most of work	king 1	6b. Kind of Business/Ir	ndustry
7	filad within Hygiana. ther than " ent, the Me	dmo	Elamentary/Secondary (0-12) Collega (1-4or 5+) Superv			Governm	ent
		CC	17. Father's Nama (First, Middla, Last)	-	a (First, Middla, M		are
yıan	Hental Ked o	o Be	Daniel W. Shifflett	Mar	garet Gr	eer	
a	2 shot and N is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Strat				
eĵ oĵ	and and m 27		Jean Parsons (Niece) 6400 86th A	venue, New			
E OL	Pagas 1 nant of H int: If item iry or oth		1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata cematery, crematory or other p.			0c. Location - City or T	
2			4 Donation 5 Other (Specify) Chesapeake Crem 21. Signatura of Fureral Sarvice Licensea 22. Nama and Add			Beltsville	
n n	pemit. Depart Imports any inj			RE		e Funeral 1 m MD 20706	Home
7	Dhusisian		23a. Part. Entar tha disaasa, or complications that caused the death. Do not enter the moda of disbook, or haart failura. List only or a cause on each line.				Approximata Interval Batween Onsat and Daath
nga"	Physician /Medical	\rightarrow	Immediata Causa (Final disaasa or condition rasulting in death) a. Carcliv Pulwon	ans A	a cost		
	Examiner		rasulting in daath) Dua to (or as a consequence of):	11	1368	1	
	pe ti	niner	b				
	a be axecuted sician and a burial-transit	Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Undarlying				
	ysician	ca	that initiated evants C				
200	daath certificata I a attanding physi ad for usa as tha b	by Physician/Medi	rasulting in death) Last				
Rox	ath ce ittandi ior usa	lan	d				
o.	0 0 8	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.			to the cause of death?
7.	s that ned by e date	y Pt	Advanced Age Hyperlensin	,	1 □ Ya	s 2. No 3 □ Pro	obably 4 Unknown
ord G	Tha law raquiras that tha da ata has been signed by tha (paga 2 should be datachad	eted t	Pare maker		24a. Was an parform	ed? a	Vera autopsy findings vailabla prior to omplation of causa
He	hysician: Tha law his cartificata has b il diractor, paga 2 s	Completed			1 ☐ Ye	_/	fdeath? □Yes 2□No
Ita		Be	25. Was casa rafarrad to medical axaminar?		th (Chack only one)	
5	shysic this ca al dire	2	1 Yas 2 No Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA		oma 5 Rasider	nce 6 Other (Spec	ify)
0	Attending Physician: Ir death. Sctor: Aftar this cartific by the funeral director.	tlon	1 Natural 5 Pending (Month, Day Year) Injury W	ork? □Yes 2□No	Zod. Dascribe rio	w injury occurred	
Division of Vital Records,	To the Hospital or Attending Phys within 24 hours aftar death. Yo the Funeral Director: Aftar this completely filled in by the funeral directors.	Certification:	3 ☐ Suicida 4 ☐ Homicide 6 ☐ Could not be datermined 28a. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)	e	28f. Location (Str. City or Town,	eat and Numbar or Rui Stata)	ral Routa Number,
	hours a neral D		29a. Certifiar (Check only 2 Medical Examiner: On the best of my knowledge, death occurred at that				
	thin 24 the Fu	Medical	one) and mannar stated.	nsa number		d. Data signed (Month	
•	1 1 1 8)	Arid M. meht NO I	> 2732	56	8/2/0	4
	200		30. Nama and addrass of person who complated cause of daath (Item 23a) (Type, Print) 7 100 Balti wal Au 4 509 Williage Po	alc m	20	740	
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 3 2004			-	

				-		epartment of F		•		
			For State Registrar	State of Mai		Certificate of			Reg. No.	25076
			Decedent's Name (First, Middle, Last)					2. Date of De.	ath	3. Time of Death
	Physicia /Medic		Elizabeth	A. Ka	gey			J.Month	Day Year	
>	Examin		4a. Facility Name (If not institution, give st	reet and number)	7 /		r Location of Deat	h	4c. County of De	ath
			Shady Grove t	Advent +	Hosp.tal	Rockvill	If Under 24 Hrs	0.0-4(0:4	Montgome	
	Funeral Director		5. Social Security Number 6. Sex 1 1	M 2∭ F 7. Age (In yrs. last birth	Months Days	Hours Min.	8. Date of Bird (Month, Da Aug • 24	$y, Y \theta a r)$ (inthplace (State or Foreign Country) Shington, D.C
			Usual Residence of Decedent				1			
	arylar show	_	10a. State 10b. County		IOc. City, Town					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	the M	Director	Maryland Frederick		Mount A	10f. Zip Code			10g. Citizen of What (
	3a or		6107 Ridgeline Driv	e		21771			USA	ountry :
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ta M. ofce Exertinal must be notified at	Funeral		2. Was Decedent Ev	er in U.S.	13. Was Decedent of H	Hispanic Origin? (S	Specify Yes or No	- 14. Race - An	
9	after or Ite	/ Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give		1 ☐ Yes 2 XNo	Specify:	to nican, etc.)		
Maryland 21215-0036	hours	d by	3 Widowed 4 Divorced	Year or Dates:	100 5				WI	nite
7	Jwithin 72 ho piene. r than "natur It e Medical	Completed	15. Decedent's Educ (Specify only highest grade	completed)		Decedent's Usual Occup 'Give kind of work done life. DO NOT use retire	during most of wo d)	rking	16b. Kind of Busines	s/industry
212		mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Of	fice Manage	er		Contractor	
pu		Be (17. Father's Name (First, Middle, Last)						Maiden Surname)	
yla	should be and Mental marked c	²	Leslie Riley					Parker		
Mar	ra Tra		19a. Informant's Name/Relationship (Typ	. ,		Mailing Address (Street			Lacro Contract	
	s 1 and 2 if Health item 27 i		George I. Kagey/hus 20a. Method of Disposition	band		07 Ridgelin Disposition (Name of c, crematory or other pla		Prount A	20c. Location - City of	
<u>o</u> E	Pages nent of int: if it iry or o		1 ☐ Burial 2 XCremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		, crematory or other pla ndel Cremat		.004	Odenton, N	faryland
Baltimore,	permit. Pages 1 Department of H Important: if iten any Injury or ott		21. Signature of Funeral Service License	6/1/		22. Name and Addre	ess of Facility	on Servi	ice P.O. H	30x 784
<u>m</u>	99559	. 113	Devely & He	the	MO125	Beverly L.	Heckrot	te. P.A.	. Clarksvil	1e, MD 21029
п			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the cause on each line	ne death. Dono	ot enter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	1	Immediate Cause (Final disease or condition resulting in death)		ranial	bleed				< 1 day
	Examiner		1	Due to (or as a	consequence of	11ths =				6-7 months
	A	Jer	Sequentially list conditions, b.	D so o (or as a	consequence of	m - MIDTAE				7.40.745
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
,092	te be executed ysicien and te buriat-transit		resulting in death) Last	Due to (or as a	consequence of	f):				
687	eath certificate be executed attending physicien and for use as the burial-transit	dical	d.							
Box 6	certif nding use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Date of d	elivery
	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti 9□Unknown		3 □Ectopic pregnanc 5 □ Other (specify) _	y 		Month	Day Year
P.0	that the de led by the a detached	Phys	9 Unknown							
	Se F 0	by	Part II. Other significant conditions cont Metastaki Sma		-	the underlying cause giv	en in Part I.	23e. Did t	obacco use contribute Yes 2 No 3 1	to the cause of death? Probably 4 Dunknown
Records,	w require been sig	Completed	MC I W I RING THE	" CCIT CA	10	incon ja.		24a. Was		
Rec	he lav e has ige 2:	dmo						autor	prior to death?	
Vital	slcian: The certificate har rector, page	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o	2 No 1 Ye	s 2 No
of Vi	nyslci nis cer i direc	To B	examiner? 1 Yes 2 No	ospital: 1 Impatient	2 ☐ ER/Out	patient 3 DOA	200		dence 6 □Other (Sp	ecify)
0 0	ding Ph h After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Ti	jury Wa	rk?	28d. Describe I	how injury occurred	
Division	ttend death tor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	29a Place of Injur	y . At home far	M 1m, street, factory, office	Yes 2 □ No	29f Location (Street and Number or I	Dural Barta Numbar
Di≤	effer Offer Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	m, street, factory, office		City or Tox	wn, State)	nural House Number,
	To the Hospital or Attanding Physician: within 24 hours effer cleath To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge,	death occurred at the ti	me, date and place	e, and due to the	cause(s) and manner	as stated.
	the Holin 24	Medical	one)	and manner state	examination and ed.	Vor investigation, in my				
	To To con	2	29b. Signature and title of certifie	MA-A		29c. Licens	se number	2.7	29d. Date signed (Moi	nth, Day, Year)
	ML		Jell 1. A		nah (lag gg.) =	J VO	0 184	7).	277 68, 5	.009
	Char.		30. Name and address of person who con	uitre	atn (Item 23a) (1 891 D	Type, Print) Medical T	Drive	Gaithe	JJ, 28, 2	20810.
	Sta	ate	31. Date filed (Month, Day, Year) 31. 2004	Registrar	's Signature	(control			11 - 1	
	Regist	rar	JUL 3 1 2004	Place	H .	have.				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 10:10 P™ AUGUST 1. 2004 D00 RE KIM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 KOREA 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 ☑ F 218-59-4015 78 Director JAN. 20, 1926 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MONTGOMERY WHEATON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Itema 23a 14124 GRAND PRE RD. APT. 14 20906 KOREA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: à ASIAN 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 1) WN 6 othert 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental ant: If Item 27 is marked o UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14124 GRAND PRE RD. APT. 14 WHEATON, MD 20906 KIM SUNG SOO (HUSBAND) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) NORBECK MEMORIAL PARK 8/4/04 OLNEY, MD 22. Name and Address of Facility 21. Signature of Funeral Service License PEYTON FUNERAL HOME 0 Wyser 2205 S. SHIRLINGTON RD. ARL, 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of); **Examiner** 0 Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 □Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0021033 CK 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000 Georg 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylan		artment of rtificate o			Reg. No. 2	004	25978
	Physicia /Medic Examin	al .	Decedent's Name (First, Middle, Last) CATHERINE DUKE 4a. Facility Name (If not institution, give:	KLING		4b. City, Town	, or Location o	2. Date of Month JULY	16, 4c. Cou	2004 nty of Death	3. Time of Death 10:30P.M
	Funeral Director		BOWIE ASSISTED LIV 5. Social Security Number 6. Security Number 1081–07–6087		last birthday) Yrs.	BOWIE If Under 1 Yea Months Day		Min. (Month,		Cour	place (State or Foreign
	the Maryland 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND PRINCE (10e. Street and Number		y, Town or Lo	ocation 10f. Zip Code	9		10g. Citizen		10d. Inside City Limits 1 X Yes 2 □ No
036	be filed within 72 hours after death with the Maryland lat Hygjene. d other then "neturel", or Items 23e or 28e-f show event, the Medical Examer must be notified at	by Funeral	16206 PENN MANOR	LANE 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		20716	of Hispanic Ori uban, Mexicar	gin? (Specify Yes or n, Puerto Rican, etc.)	U.S.A	A . Race - Americ Black, White,	can Indian,
121215-0036	e filed within 72 ho al Hygiene. other then "netur vent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 10	cation e <i>completed)</i> College (1-4or 5+)	(Give life.	dent's Usual Occ kind of work dor DO NOT use reti	ne during mos ired) ER	it of working or's Name (First, Mid	OWI	f Business/In N HOME	
Maryland	2 should be fi and Mental h Is marked ot eumatic ever	To Be	MICHAEL DUKE 19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ng Address (Stre	MAR]		GALANT		Code)
di.	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke eny injury or other treumatic QDC9.		DORIS M. KLING/DA 20a. Method of Disposition 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	Place of Disponentery, creation PATR	osition (Name of matory or other p ICK [†] S	olace)	Date JUL 20, 20	04 PENNS	on - City or To HERN C	AMBRIA,
Balt	permit. Departi		21. Signature of Funeral Service Licens		1	6000 AN	NAPOLIS	S ROAD, BO	WIE, MA		UNERAL HOME 20715 Approximate
	Physician /Medical Examiner	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ne cause on each line. a	EPS quence of):	15		Infection			Interval Between Onset and Death Olays downs
. Box 68760,	death certificate be executed attending physician and of for use as the burial-transit	Physician/Medical Examin	resulting in death) Last	d	ancy	⊒Ectopic pregna ⊒ Other (specify,				Date of delive	ery Day Year
ds, P.0	The law requires that the de ate has been signed by the a bage 2 should be detached	by		ntributing to death but not res		underlying cause	given in Part I		id tobacco use c		he cause of death?
al Record		Completed	Cevebro Vasc	mlar acuid	ent			a	utopsy erformed?	b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
ion of Vital	tending Physicien: These.th. tor: After this certificate the funeral director, pag	ation: To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of 28c. In					MARISTED
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in 1y the fune	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special Special			City or	Town, State)		al Route Number,	
•	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in y	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examin and manner stated.	ation and/or in	nvestigation, in m	ense number	ath occurred at the tir	me, date and pla	gned (Month,	o the cause(s)
_			30. Name and address of person who co	e Rd #10	3 1	Print) J	Shes	20716	9	,	
	St Regist	ate rar	31. Date filed (Month, Day, Year) 2004	d2. Registrar's Sign	ature						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Month Year **Physician** 18:15 Bradley Kocheniec

4a. Facility Name (If not institution, give street and number) August **C**3 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Belhmore City Belhmore, Marzland Mery Medical Canter If Under 1 Year If Under 24 Hrs.

Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN . 25 , 1985 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1**X**]M 2□ F 19 FLORIDA Director 593-68-7161 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director FREDERICK SABILLASVILLE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21780 15028 QUIRAUK SCHOOL RD. Funeral death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or its any injury or other traumatic event, the Medical Examina. 1K Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) EDUCATION STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE KOCHANIEC ပ CAROL RICE McINTOSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15028 QUIRAUK SCHOOL RD. SABILLASVILLE, MD 21780 CAROL MCINTOSH/ MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 Other (Specify) ST. MARY'S CEMETERY 8/10/04 EMMITSBURG, MD. 21727 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN_ST. EMMITSBURG, MD. 21/2/ 23a. Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseas) or condition resulting in death) Physician Seps. 5 /Medical Due to (or as a consequence of): **Examiner** Aspirohm Preummin Sequentially list conditions, Due to or as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | 1 Ves 2 No 9□ Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Bru.n 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has this certificate 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Nothin 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 03 2004 mmis P15847 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Billimre M7 301 21202 Dered Braus 31. Date filed (Month, Gan Y 3") 2004 32. Jegistrar's Signature State Registrar

_			1 - For State Registrar	State of Maryla		artmer	t of H		d Mental H		e 2001	25980
	Physic	ian	Decedent's Name (First, Middle, Last)	")					2. Date of t		ay Year	3. Time of Death
	/Medi		Aurora Caberte La						Ju1y		2004	11:50 a ^M
4	Exami	ner	4a. Facility Name (If not institution, give					Location of D	eath		c. County of Dea	ith
			Laurel Regional E 5. Social Security Number 6. Se.		s. last birthday)		ure1	If Under 24	Hrs. 8. Date of B		rince G	
L	Funeral Director		212-37-7989	2M 2MF 74	**	Months	Days		Hrs. 8. Date of E Min. (Month, I October	Day, Year 15,		thplace <i>(State or Foreign</i> ountry) ilippines
	and **		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	reation						10d. Inside City Limits
	dary! f sho	ō	Maryland Prince Ge			, oation						1X Yes 2 □No
	28a-	Director	10e. Street and Number	eorge s L	aurel_	10f. Zig	Code			10g C	itizen of What Co	
	3a or	0	8721 Contee Road,	Ant #202			20708)				ountry !
	death	Funeral		12. Was Decedent Ever in	U.S. 13.				? (Specify Yes or Nuerto Rican, etc.)	10-	S . A . 14. Race - Ame	
9	after or the rolos	F	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		it Yes, sped 1 ☐ Yes		n, Mexican, Pi Specify:	uerto Hican, etc.)		Black, Whit	te, etc.
93	ural',	d by	3 Widowed 4 Divorced	Year or Dates:		111185	2 <u>10</u> 1 NO	эрөспу.			Specify: Pl	nilipino
7	"nati	lete	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usua kind of wo	al Occupa rk done d	ition luring most of)	working	16b. F	Kind of Business	/Industry
21215-0036	withir ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen		se retirea,	,			O II	
9	nd 2 should be filed within 72 hours after death with the Maryland aith and Mental Hygiene. 27 Is marked other then "natural", or Items 23a or 28a-f show ir freumatic event, the Medical Evanting must be incitified at		17. Father's Name (First, Middle, Last)		Homen	iakei		18. Mother's	Name (First, Middle		Own Home	
Maryland	ld be ental ked ic ev	To Be	Potenciano Cabert	·e					na Calip		,	
ary	shou ind M mar umat	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address	(Street a		Rural Route Num		or Town, State, a	Zip Code)
Ž	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23a or 28a-f show other treumstic event, The Medical Examiner must be inclifted at		Marlyn Buchanan -	Daughter								land 20708
Baltimore,	permit. Pages 1 a Department of Hea mportent: If item sny injury or othe		20a. Method of Disposition	20b.	Place of Dispo cemetery, crer	sition (Nan	ne of ther place	9)	Date		ocation - City or	
Ĕ	Pages nent of I ent: If its ury or o		1 ☐ Burial 2 \ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)						/28/2004	Ale	xandria	, Virginia
alt	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service License		22	. Name an	d Addres	s of Facility	Gasch's	Fune	cal Home	, P.A.
-	80,5 29		· Cloudette.	Lasch Lan					ve., Hya		ille, MD	20781
	Enysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the dea ne cause on each line. AMetastatic	Lung C			j, such as card	diac or respiratory	arrest,		Approximate Interval Between Onset and Death 2 Years
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Ical Examiner	if any, leading to immediate cause. Enter Underlying Cause Disease or hijury	Due to (or as a consect. Due to (or as a consect.							es	
	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3 ☐	Ectopic pro					23d. Date of deli Month	ivery Day Year
	es Ded	by	Part II. Dther significant conditions con	ntributing to death but not re	sulting in the ur	derlying ca	ause give	n in Part I.				the cause of death?
Ö	w requir been s should	ete							-		T	
<u>د</u>	The ate h page	Completed							24a. Wa: auto perf 1 Tes	s an opsy ormed? 2 \(\Omega\) No	prior to death?	topsy findings available completion of cause of 2 No
ΖÏ	9 9	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: .v-,	1====		Other		eath Check only			
of		H	27. Manner of Death	1. Inpatient 2	28b. Time of	-	A Be Injury	` 4 ☐ Nursing at	Home 5 Res			cify)
O	tending leath. tor: After the fune	tlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M	3c. Injury Work?	es 2 □ No	20d. Describe	now injui	y occurred	
Division		fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, stre				28f. Location	Street an	d Number or Ru	ral Route Number,
á	el or A s effer al Dire	Certification:	4 Homicide	building, etc. (Speci	fy)	-,,			City or To	wn, State)	out route runner,
	To the Hospitel or At within 24 hours efter of To the Funerel Directompletely filled in by	edical (29a. Certifier 1	sician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred a estigation,	at the time in my opi	, date and pla nion, death oc	ice, and due to the curred at the time,	cause(s) date and	and manner as I place, and due	stated, to the cause(s)
	To the h within 24 To the F complete	M	29b. Signature and title of certifier	- ^		29c.	License	number		29d. Dat	e signed (Month	, Day, Year)
			Kita Hu	bla nio			D0047	7707		Ju	ly 23, 2	2004
	CR		30. Name and address of person who con	mpleted cause of death (Iter	п 23а) (Туре, Р					54	- J 2 J 9 Z	
	VP		Rita Pabla, MD 13	3621 Baltimor	e Aveni	ie, La	aurel	L, Marv	land 207	07_		
	Sta Registr	te ar	31. Date liled (Month, Day, Year) JUL 2 6 2004	2. Registrar's Signa	ature							

			Ol-4-	Pepartment of Health and Certificate of Death	•	
	Physic /Medi			LEWIS	2. Date of Death July 25	Day 2004 4.41 p.M
	Examir	ner	4a. Facility Name (If not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Deal Lanham	P	4c. County of Death rince George's
	Funeral Director		5. Social Security Number 577-54-5106 6. Sex 1 M MM 7. Age (In yrs. last birtl) 1 Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		
	e Maryland 8e-f show	ctor	MD. 10b. County 10c. City, Town New Car.			10d. Inside City Limits 1 Yes 2 □ No
7.3	th with th 23e or 26 ust be no	Funeral Director	10e. Street and Number 7769 Riverdale Rd. Apt. T-2	101. Zip Code 20784	10g. (Citizen of What Country? USA
The	d 21215-0036 illed within 72 hours after death with the Maryland Hygiene ther than "natural", or Items 23e or 28e-1 show ont, the Medical Exeminar must be notified at	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married XX Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes ※XX No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
	Maryland 21215-0036 d 2 should be liled within 72 hours alt th and Mental Hygiene i? Is marked other than "natural", or traumetic svent, the Medical Exam	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Home Maker	rking 16b.	Kind of Business/Industry
5	aryland 2 should be filed and Mental Hygi s marked other umetic svent, I	To Be C	17. Father's Name (First, Middle, Last) Norman Harris		ne (First, Middle, Maid ae Hawes	,
	re, Maryle 1 and 2 should Health and Mer tem 27 Is marke			Mailing Address (Street and Number or Ri 59 Riverdale Rd. T-2		
Dorcth	Baltimore, N permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr			Disposition (Name of committee) 7/31, wet Cametery 22. Name and Address of Facility Bianchi F.S. 814 Upshur		Location - City or Town State shington, DC.
M	Physician and particular and private and p	Ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	pra Pareline	disero	Conset and Death
	Hecords, P.O. Box 68/60, The law requires that the death certificate be exite has been signed by the attending physician age? should be detached for use as the burian	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 100 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	COTGS, P w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		o use contribute to the cause of death? 2 ╚️ᠬる 3 ☐ Probably 4 ☐ Unknown
(Completed	Haboto Melli	he	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \sum Yes 2 \sum No
	of VIta Physician: this certifical	o Be	25. Was case in ferred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Topatient 2 ☐ FR/Outr	0#	th Check only one)	
	DIVISION OF To the Hospital or Attending Phys within 24 hours eiter death. To the Funeral Director: Affer this completely filled in by the funeral di	Η,	27. Manner of Death 28a. Date of Injury 28b. Tir	Attent 3 DOA 4 INUISING H	ome 5 Residence 28d. Describe how inj	
	DIVIS tal or Atte rs efter der al Directo ed in by th	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	the Hospi in 24 hour the Funer	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner state.	or investigation, in my opinion, death occu	and due to the cause(rred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
	To To com	M	29b. Signature/and/fittle of certifier	29c. License number MOD 3157	8 7.	ate signed (Month, Day, Year)
	CR 3 Sta Registr		30. Name and address of person who completed cause of death (Vern 23a) (III) ALCAN (III) 8 (III) 31. Date filed (Month, Day, Year) Registrar's Signature	MOD3157 WOODER ROAD CH	EVERCY, A	ud 20185

State of Maryland / Department of Health and Mental Hygiene For 7-30-04 State Amend #30.Per Phys. PGC cr Certificate of Death Reg. No. 25022 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary **Physician** Α. Logan JMMTy 27 2004 2:15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5266 Marlboro Pike Apt#301 Capital Heights, Md. P.G. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days April 24,47 Bedford, Va. Min 578-64-7231 1 ☐ M 2 🔀 F Hours 57 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location in then "natural", or Items 23s or 28s-f show 10d. Inside City Limits P.G. Md Capital Heights, Md 20743 Director 1 ☐¥es 2 ☐ No 10f. Zip Code 20743 10e. Street and Number 10g. Citizen of What Country? 5266 Marlboro Pike Apt# 301 U.S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 72 12 should be filed within h and Mental Hygiene. 7 is marked other then. Elementary/Secondary (0-12) College (1-4or 5+) P.G.County Schools Satellite Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fannie Cassey Be Lawerence Curtis permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked eny injury or other traumatic every. ပ 19a. Informant's Name/Relationship (Type, Print) Leroy Logan III - son 19b. Maijing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Gode)*7403 Waldran Ave. Temple Hills, Md
20748 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony Memorial 20a. Method of Disposition Aug. 3,04 Landover, Md. Date 1 DBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 20001 Robinson Funeral Home 1313 6th Street N.W. 23a. Part 1. En ey the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in eart failure. List only one cause on each line. Washington, D.C. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) Physician GASTRIZ CARGNOMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.0. ed by the a been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed es 2 No 1 Yes 1 ☐ Yes 2 ☐ No director 25. Was case referr to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 V No this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 24 hours after death.

Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one within 2 the 29b. Signa and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 009526 runo MD impleted cause of death (year 23a) (Type, Print)
85 Little laturent Barkway, #104, Columbia, MD 21044 . Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 3 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** JULY 2004 1:10a M GLORIA WINSTON LEE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 3, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F 49 Wash., D.C. Director 577-76-7323 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner wast be notified at 1 AYes 2 No Director Prince George's Fairmont Heights 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ō 20743 United States Items 23a 604 60th Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12th Security Guard Security if Health and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnny Winston 2 Viola Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeShon R. Washington/Daughter 204 Lynhaven Dr. Alexandria, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of thimportent: if ite any injury or ot once. 1 Burial 2X Cremation 3 Removal from State
4 Donation 5 Other (Specify)
21. Signature of Funeral Service Licenser CMesapeake Crematory 7-26-04 Beltsville, Md. 22. Name and Address of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 23a. Part . Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. ater the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 6 /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) sician P.O. Box 68760. Physician/Medical the attending phy IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No this certificate has I 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 █ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 X Natural 5 Pending To the neapone within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ŝ 29b. Signature and Atte of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-21-04 Clasa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIERSON WENDELL 3001 HOSFITAL 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year FOSTER P^{M} JULY 21, 2004 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Althea Woodland Nursing Home Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1 1 1 1 4 1 933 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 70 Director 237-50-8781 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location item 27 is marked other then "netural", or items 23a or 28a-f show other treumatic event, if a Medical Eventier must be notified at 10d. Inside City Limits MD Prince George's Lanham Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7103 Greenspring Lane 20706 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other then "netural", or Iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +4 yrs Teacher City Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clinton Foster Calise Taylor ဂ 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or other treum <u>once</u>. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony F. Lewis - Son 7103 Greenspring Lane; Lanham, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cem. 07/24/2004 Brentwood, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Eacility Robert O. Freeman Funeral Services, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20002 Approximate Interval Between Onset and Death Immediate Cause (Final 1etaslatic Esophapeal Priysician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, any, leading to time ediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a nonsequence off The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the a 9□ Unknown 9 🗆 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 XUnknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 1 Yes 2 No To the Hospitel or Attanding Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No After this of 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07-23-04. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (5)laudoretille MD 20784. Neolam Ashai 4410 74th Ave M.D 31. Date filed (Month, Day, Year)
JUL 2 8 2004 32. Registrar's Signature Registrar

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be rotified at once.

Pnysician /Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Lav	wson Please	Type or Print in Black	k Indelible Ink. E	nsure All	Copies Ar	e Legible.	
	For State	State of Maryland / D	epartment of Hea	alth and Me			25
-	Registrer		Certificate of De		Reg.	No. ZUUL	25985
ian	Decedent's Name (First, Middle, La	.SI)			2. Date of Death	Day . Year	3. Time of Death
ical	George H. Laws	on			July 20,	^{Day} 2004 Year	0107 A M
iner	4a. Facility Name (If not institution, give		4b. City, Town, or Loc	cation of Death		4c. County of Death	
	Malcolm Grow Med		Andrews A		Base	Prince G	eorge's
		Sex 7. Age (In yrs. last birth	Months Days H	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
	220-32-2382	68 Y	rs.		June 17,	1936 Ma	rýland
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				104 1-14-01-11-1
5							10d. Inside City Limits 1 ☐ Yes 2 No
ect	MD Prince G	eorge's Co. Upper	_Marlboro		· · · · · · · · · · · · · · · · · · ·		TEL TES ZENINO
by Funeral Director	10e. Street and Number		10f, Zip Code			Citizen of What Cou	intry?
ā	6605 Hallam Driv		20772			U.S.A.	
une	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispan If Yes, specify Cuban, M 	nic Origin? (Spec	ify Yes or No-	14. Race - Ameri Black, White	
Y F	1 Never Married 2 Married	1X Yes 2 □ No If Yes, Give		pecify:	,,		hite
Q P	3 Widowed 4 Divorced	Year or Dates:				Specify.	
ete	15. Decedent's E (Specify only highest gra	ade completed) (Decedent's Usual Occupation (Give kind of work done durin	n ng most of workin	a 16b	. Kind of Business/Ir	ndustry
d H	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)				
Be Completed	12 17. Father's Name (First, Middle, Last,		otographer			mputer Sc	ience Co.
Be					(First, Middle, Maid	den Sumame)	
ို	John H. Lawson			Sadie G	lass		
	19a. Informant's Name/Relationship (Mailing Address (Street and I			,	
			5 Hallam Driv	e, Upper	r Marlbo	ro, Maryl	and 20772
	20a. Method of Disposition 1 X Burial 2 Cremation 3 Z	Removal from State 20b. Place of E	Disposition (Name of r, crematory or other place)	July	¹² 24. ^{20c}	. Location - City or T	own, State
	* 4 □ Donation 5 □ Other (Specif	w) America	n Legion Cem.	1		Stone Ga	p, Virginia
1	21. Signature of Fundamental Cell Cer	1500	22. Name and Address of	Facility Lee			
	Mighed by Le	50 y	8125 Souther	n Maryla	and Blvd.	, Owings,	MD 20736
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do no	ot enter the mode of dying, su	uch as cardiac or	respiratory arrest,		Approximate
L	Immediate Cause (Final		NOCK T.	100			Interval Between Onset and Death
	disease or condition resulting in death)	a Due to (or as a consequence of	Neck Ing	uries			
			, U				
je	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequence of	r):				
Examine	Cause (Disease or injury that initiated events					1	
Exa	resulting in death) Last	Due to (or as a consequence of)	·):				
		d.					
Completed by Physician/Medical		. 0,					
M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				204 0-1	
cial	in the past 12 months?	1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deliv Month	Pery Day Year
ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	J Other (specify)				
4	Part II. Other significant conditions of	ontributing to death but not resulting in t	the underlying cause given in	Part I	23e. Did tobaco	o use contribute to t	the cause of death?
Q P			,			2 No 3 Pro	
ete					103	2/2110	
npi					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Ö					performed		2 □ No
Be	25. Was case referred to medical examiner?		26.	Place of Death (Check only one)		
Jo	X 163 2 110	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3[XDOA Other: 4	☐ Nursing Home	5 Residence	6 ☐Other (Special	(ty)
on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at Work?	28	d. Describe how in	jury occurred	
ati	2 X Accident investigation	11(7)(04) 11	:36 PM 1 □ Yes	2/2/40	subject -	teil down	1 Stairs
ij	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28	f. Location (Street	and Number or Run	al Route Number.
Cer		Home		1	LDDEV H	ate) 6605 H	4D
Medical Certification;	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exem	sicien: To the best of my knowledge of	death occurred at the time, da	ate and place, an	d due to the cause	(e) and manner as s	stated.
edi	one)	iner: On the basis of examination and/o	or investigation, in my opinion	n, death occurred	at the time, date a	and place, and due t	o the cause(s)
Σ	29b. Signature and title of certifier		29c. License nun	nber	29d. I	Date signed (Month,	Day, Year)
	l'aine +	talog a hid	O.C.M.E	Ξ.	Ju	ly 20, 200	04
	30. Name and address of person who co	ompleted cause of death (Item 23a) (To	ype, Print)				
	Cavol H. Alla	en nd 1	11 Penn Stree	et, Balt	imore, Ma	aryland 2	1201

8+1

State Registrar 🕏 Signature

31. Date filed (Month, Day, Year)

32. Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** July 2004 10:10 A^M Shirley M. Lowe 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5008 Ilchester Road Ellicott City Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 200 F Yrs. 69 Director May 1, 1935 Maryland 217 30 4367 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ehow. item 27 is marked other than "natural", or itema 23a or 28a-f ebov other traumatic event, the Medical Examiner must be routified at 1 ☐ Yes 2 ☑ No Ellicott City Directo MD Howard 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21043 5008 Ilchester Road United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home permit. Pages 1 and 2 should be file.
Depertment of Health and Mental Hy important: If tem 27 is marked oths any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Piquett Garland Shamer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard H. Lowe, Jr./Husband 5008 Ilchester Road Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 7-29-2004 Ellicott City, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Ohen 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Division of Vital Records, 3 Probably 2 🗆 No 4 Unknown 1 TYes Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 2 XNo 1□ Yes Hospitei or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) Medi To the 29b. Signature and title of continue 29d. Date signed (Month, Day, Year) July 27, 2004 はるか 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATORSVILLE MO 2/228 CHOICE (ANE 716 Marden 32. Rigistrar's Signature 31. Date filed (Month, Day, Year) State JUL 28 2004 Registrar

		·	1 - For State Registrar	· ·		d / Depa		t of H	ealth a	and M		iene 9. No.2	004	25987
	Physicia	an	1. Decedent's Name (First, Midd Mary Reudine								2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution		harl		4h City	Town or	Location of	of Doath	July	19,	2004 ounty of Death	8:13 p M
	Examin	er	Anne Arunde	-			4b. City,		napo.				Anne Ar	undel
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. I	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign
	Director		213-12-0860 Usual Residence of Decedent	1□M 212 F	84	Yrs.	Months	Days	Hours	Min.	Jan. 5,			MD
	Marylar f show	tor	MD Anne	e Arundel	10c. City	y, Town or Lo		nnap	olis					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	n the	irec	10e. Street and Number				10f. Zip				10	og. Citize	n of What Cou	ntry?
	th wit	ai D	800 Bestgate 1	Road				214	101				USA	1
21215-0036	within 72 hours after death with the Maryland ene. Itan "natural", or Itams 23a or 28a-f show he Medical Examinar must be notified at	l by Funerai Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorced	12. Was Deced	ces? 2. <mark>∑</mark> No		Was Deced f Yes, spec 1 ☐ Yes			gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		Black, White, pecify: Whi	etc.
5-0	72 ho	etec	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced (Give	kind of wor	rk done a	luring mos	t of worki	ing	16b. Kind	of Business/In	dustry
121	within ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. i	DO NOT us HON	ie retired, nemak					Home	
and 2	s 1 and 2 should be filed within 72 hc It Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical	Be	17. Father's Name (First, Middle, August Reudin		-				18. Mothe		(First, Middle, M Robinet			
Maryland	2 should be and Mental Is marked o sumatic eve	2	19a. Informant's Name/Relation:			19b. Mailir	ng Address	(Street a			al Route Number,		own, State, Zip	Code)
	s 1 and 2 s if Health ar itam 27 is other trau		Elizabeth Woo	dard/Daught		6 A			t, Ste		sville,		21666	
Baltimore,	m O		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		tota Co	ouden F	natory`or o	ther place	ery	Jul	y 23, 004		tion - City or To timore,	
Balti	permit. Page Department of Important: If any injury or once.		21. Sign were of Fundal Service	Liegra		Ba 49	Name an arrance 5 Gov	d Addres	s of Facilit Sons Ltchio	P.Z e Hw	A. Sever	na P	ark Fur ark, MI	neral Home 21146
	Physician /Medical Examiner	-	shock, for heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a Due to (o	used the death ch line. or as a consequence or a consequence	uence of):	er the mod		g, such as	74	or respiratory arre	st,		Approximate Interval Batween Onset and Death
Box 68760,	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Uniderlying Cause (Disease or injury that initiated se or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the cast 12 months?	c	or as a consequ	uence of):]Ectopic pr	egnancy				230	I. Date of delive	*
o.	at the dea by the at tached fo	hysici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregna 9□ Unknov	nt at time of de		Other (sp.						Month	Day Year
rds, P	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Other significant conditi	ons contributing to dea	ath but not rest	alting in the ur	nderlying ca	ause give	n in Part I.		23e. Did tob	1		ne cause of death?
al Record		Completed						-			24a. Was an autopsy perform		prior to con death?	psy findings available mpletion of cause of 2 No
Vital	S C S	o Be	25. Was case referred to medica examiner?	Hospital:				Othe			(Check only one			
of	Phys	\vdash	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatien 28b. Time of		8c. Injury Work	at □ Nu		me 5 Resider 28d. Describe hov			y)
ion	Attanding F ir death. actor: After by the funer	atior	1 Natural 5 Pendi 2 Accident invest	ng (Month igation	, Day Year)	Injury	М		? ′es 2 🗀 i	No				
Division	F F C	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 286. Place C	of Injury - At ho g, etc. (Specify	me, farm, str	eet, factory	, office		2	28f. Location (Str. City or Town,		lumber or Rura	l Route Number,
	Hospita 4 hours Funaral tely filled	Medical C	29a. Certifier (Check only one) 1 Sertifyi 2 Medical	ng Physician: To the base	sis of examinat	wledge, death ion and/or inv	occurred a	at the tim in my op	e, date and inion, deal	d place, a	and due to the car ed at the time, da	use(s) an te and pla	d manner as st	ated. the cause(s)
)	To the within 2 To tha complet	Me	29b. Signature and title of certifie		D		29c	. License	number	7	29	d. Date s	igned (Month)	Day, Year)
			30. Name and address of p	who completed cause	of death (Item	23a) (Type,	Print)	A	1	. (M.I.		Can	L.
	Sta Registr		31. Date filed (Month, Day, Year JUL 2)		gistrar's Signat	d A	met.	7	00					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mary E. Lookingbill Month Dey **Physician** August 2004 4:25 P /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll County 4025 Harney Road Taneytown 8. Date of Birth Country)
Apr. 10, 1917 Maryland If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 220-03-2215 87 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10h. County ital Hygiene. od other then "naturel", or Items 23e or 28e-f shov svent, Ite Medical Exander must be nollflied at 1 ☐ Yes 2X No Maryland Carroll County Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21787 4025 Harney Road United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Item say injury or other traumatic event, the Mental Property on the Company of the Co Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) factory worker garment manufacture 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alvah J. King Elizabeth Marie Richter ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4025 Harney Road Alvie L. Lookingbill son Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aug. 12 1X Burial 2 ☐ Cremation 3 X Removal from State Gettysburg, PA Oak Lawn Memorial Gdns 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service Licens 136 East Baltimore Street Taneytown, MD 21787 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Deal Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR DISEASE **Physician** 1. WEBKS /Medical Due to (or as a consequenca of) Examiner Sequentially list conditions, if any, leading to immediate and fits the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ed bluods 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home & Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide filled 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely and manner stated. within 2 the 29c. License number 29d. Date signed (Month, Day, Year) J) 0014317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM R. LINTHICUM, M) DAE KINGS DRIVE, TANEYTOWN, MD 2,787 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 3 2004 Registrar

			For State Registrar	State of Mary		artment of F			iene	11. 25000	
	Physici	an	Decedent's Name (First, Middle, Last) Eugene	McGriff				2. Date of Deat Month July	h Day	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give s Washington Adv	treet and number)	pital		r Location of Dear	th	4c. County of	04 12:47 P ^M Death ntgomery	
	Funeral Director		5. Social Security Number 264-03-1983 Usual Residence of Decedent	M alle	yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year)	9. Birthplace (State or Foreign Country) Florida	
	e Maryland te-f show	ctor	10a. State 10b. County DC	100	c. City, Town or Lo		ington			10d. Inside City Limits 1 X Yes 2 □ No	
	3a or 28	I Director	10e. Street and Number 2700 Jasper S	t., S.E.	1	0g. Citizen of Wh	at Country? ted States				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avent, the Modical Examinational Legisled at 000s.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Amed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H 1 Yes, specify Cuba 1 ☐ Yes 2 🗓 No		Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc. Black	
Maryland 21215-0036	within 72 ho ene. than "natur he Modical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 10th		rking	16b. Kind of Busi	ness/Industry				
land 2	ld be filed ental Hygi ked other ic avent, II	To Be Co	17. Father's Name (First, Middle, Last) Jesse McGriff			Golf Inst		me (First, Middle, M Mamie			
Mary	d 2 shouth and M 7 is martranmat	-	19a. Informant's Name/Relationship (Type					ural Route Number	00000000	Contract Con	
Baltimore, I	ages 1 and of Healt titlem 2 y or other		Janet L. McGrif 20a. Method of Disposition 1X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	Ob. Place of Dispo	sition (Name of natory or other plac	ce)		20c. Location - C	NO11 ity or Town, State	
Baltir	permit. P Departme Importen any injur:		21. Signature of Funeral Service License			. Name and Addre	ss of Facility S	tewart Fu , N.E. Wa	neral Ho		
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8760,	Medical Examiner bhysician and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, reading to minerally cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nauquanca (1):	ure k	ZENAC LM SCO	PALL	URE	= 3 months = 2 days	
.O. Box 68	death certif e attending od for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pi 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy	,		23d. Date (
	sign sign d be	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.		_	ute to the cause of death?	
Vital Records,	The law ate has b page 2 sl	Completed					111	prio dea No 1	ore autopsy findings available or to completion of cause of ath?		
of	ding Phys h. After this funeral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation	ospital: 1 Minpatient 28a. Date of Injury (Month, Day Ye.	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗌 Nursing F	ath <i>Check on one</i> Home 5 ☐ Reside 28d. Describe ho	nce 6 Other		
Division	or in ite	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	eet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	the Hospital nin 24 hours a the Funeral I npletely filled	edical (29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	ician: To the best of moner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the tin restigation, in my o	me, date and place pinion, death occu	e, and due to the caurred at the time, da	use(s) and mann ite and place, and	er as stated. d due to the cause(s)	
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7	Am 3		30. Name and address of person who co	1	(Item 23a) (Type,	Print) 760	0 5 29 2 0 Carrol	1 Ave.,	TAI TAI	COMA PARK, MD	
14	Sta Registr		31. Date filed (Month, Day, Year) JUL 2 8 2004	32. Registrar's S		•	NOVE TO	of FINSE	1170,1110	with Price, MD	

			For Stete Registrer	State of		and / Dep	artment o		and M	ental Hy		2001	25000
	*	2	Decedent's Name (First, Middle, I	ast)						2. Date of Dea	ath		3. Time of Death
	Physici		7.1				Month 07	Day 24	Year 04	3:00P M			
	/Medic Examin		Eleanor 4a. Fecility Name (If not institution, of	McQuee			4b. City, Tov	vn, or Location	of Death	07		County of Deat	h
	⊏ ¥ainii-	ıęı			,							Montgom	
3	Funeral	10	Woodside Nursin 5. Social Security Number 6	g Home Sex	7. Age (In	yrs. last birthday	If Under 1 Y		24 Hrs.	8. Date of Birt (Month, Da			nplace (State or Foreign untry)
	Director		149-18-1444 Usual Residence of Decedent	1 ☐ M 2 📆 F	91	Yrs.	Months D	ays Hours	Min.	(Month, Da)		Mt.	Claire, N.J.
	land ow		10a. State 10b. County		10c.	. City, Town or L	ocation						10d. Inside City Limits
	Mary first	to	D. C			Washing	rton						12⊈Yes 2 □ No
	28a	Director	D.C. 10e. Street and Number			Washiri	10f. Zip Co	de			10g. Citi:	zen of What Co	untry?
	3g of		1620 Columbia	Dood N L	T #20	0	20	009		,		USA	
	ns 2	Funeral	1629 Columbia 11. Marital Status	12. Was Dec	edent Ever i	in U.S. 13.		of Hispanic Or Cuban, Mexical	igin? (Spe	cify Yes or No-		14. Race - Ame	ncan Indian,
စ္တ	within 72 hours after death with the Maryland ane. than "natural", or itams 23s or 28s-f show its Madical Examination indifficit at	y Fur	1 Never Married 2 Married	Armed Fe 1 □ Yes If Yes, G	2 X No		If Yes, specify 1 ☐ Yes 2 ☑			Rican, etc.)	1	Black, White	
ë	ural';	d by	3 ☑ Widowed 4 ☐ Divorced	Year or E	Dates:							Specify: Bla	
<u>V</u>	"nat	ete	15. Decedent's (Specify only highest)	Education grade completed)		16a. Dece	edent's Usual O kind of work of	ccupation lone <i>during m</i> os etired)	st of worki	ng	16b. Kir	nd of Business/l	ndustry
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or itams 23s or 28a-f show is marked other than "natural", or itams 23s or 28a-f show aumatic avant. The Mudical Examples in the modifier of a	Completed	Elementary/Secondary (0-12) 8th.	College (1-4or 5+)		mes ti c	etirea)					
g	othe othe	BeC	17. Father's Name (First, Middle, La	st)				18. Moth	er's Name	(First, Middle,	Maiden	Sumame)	
ılan	uld be Aenta rked tic av	To B	Luther Henders	on				Ele	anora	a Plumm	er		
lar	permit. Pages 1 and 2 should be Department of Health and Monta Important: If itam 27 is marked any njury or other traumatic a <u>once</u>		19a. Informant's Name/Relationship	(Type, Print)		19b. Mail	ing Address (Si	reet and Numb	er or Rura	l Route Numbe	er, City of	Town, State, Z	ip Code)
≥ ′`	and ealth m 27 har tr		Edwin J. Waites/	Son									D.C. 20009
Ore	or oth		20a. Method of Disposition 1	☐Removal from	State	b. Place of Disp cemetery, cre	osition (Name on Imatory or other	place)	D	ate	20c. Lo	cation - City or	Town, State
<u>E</u>	tant:		`4 Donation 5 Other (Spe		R	osedale			7·-30-	The state of the s		ge, N.J	
Baltimore,	Separation of the control of the con	1	21. Signature of Funeral Service Lic	ensee								neral H	
	AD 2 8 0		Marian	leall								, D.C.	
Ų,			23a. Part. Emer the disease, or co	ly one cause on	each line.	death. Do not er	iter the mode of	r dying, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
r	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			spirato	ry Arre	st					Immediate
1	Examiner					sequence of):	D						16 1000
		e.	Esquentially list conditions, if any, leading to immediate			Artery	Disease						15 yrs.
	nted I Insit	min	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Gen	eraliz	ed Athe	roscler	osis					30 yrs.
,	n and	Examiner	that initiated events resulting in death) Last	U		sequence of):							
760,	ate be executed nysician and he burial-transit	call		d									
	leath certificate b attending physic I for use as the b												
Вох	nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			7				2	3d. Date of deli	very
m	death a atte d for	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Preg	birth 2 □ f nant at time		⊒Ectopic pregr ⊒ Other (specif					Month	Day Year
P.O.	that the de ed by the a detached t	Physician/Med	9 Unknown	9□ Unkr	iown								
ις CL	w requires that been signed is should be det	by P	Part II. Other significant condition	s contributing to a	leath but not	resulting in the	underlying caus	e given in Part I	l.	23e. Did to	obacco u	se contribute to	the cause of death?
ğ	quire en sig uld b	pa	Multi Infarct	Dementia						1 🗆 Y	es 2X	No 3□Pro	obably 4 Unknown
Records,	s bee	ojet								24a. Was		24b. Were au	topsy findings available
æ	The lay	Completed								autop perfor	rmed?	death?	ompletion of cause of 2□ No
Vital	ician: Th	a)	25. Was case referred to medical					26. Place	e of Death	(Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
>	ysician: is certific director,	0.0	examiner? 1 ☐ Yes 2 [\$No	Hospital:	Inpatient	2 ER/Outpatie	nt 3∏ DOA	Other				Other (Spec	ifv)
Division of	ig Ph ter th neral	Certification: T	To box 1 and										.,,,
is:	death death tor: the	icat	2 ☐ Accident investiga: 3 ☐ Suicide 6 ☐ Could no	be 200 Bloo	of Injune	At home, farm, s	M Iront factors of	1 ☐ Yes 2 ☐	-	9f Location /9	Stroot and	d Number or Du	ral Route Number,
<u>></u>		ertif	4 Homicide determine	build	ling, etc. (Sp	pecify)	reet, ractory, or	nce		City or Tow			rai noble ivalibel,
_	a Hospital 24 hours a a Funaral (29a. Certifier 18 Certifying	Physicien: To th	e best of my	knowledge, dea	th occurred at t	he time, date ar	nd place, a	and due to the	cause(s)	and manner as	stated.
	To tha Hospital or within 24 hours afte To tha Funaral Dii completely filled in	edical	(Check only 2 Medical Ex	teminer: On the b	pasis of examiner stated.	mination and/or in	nvestigation, in	my opinion, dea	ath occurre	ed at the time, o	date and	place, and due	to the cause(s)
	To tha within 2 To tha complet	Ž	29b. Signature and title of certifier	0.01			29c. Li	cense number			29d. Date	signed (Month	, Day, Year)
			2 law augh	Beltin			Мо	25586			7 - 2	8-04	
	10 10	4	30. Name and address of person wh				•						
	W 4		Edward D. Belto	n MD	L629 C	olumbia	Road N	.W. Was	hingt	on, D.	C. 20	0009	
Ş	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 9 2004	Sie	negistrars S	ignature	E)						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** July 24 7:20 A M JOHN A. MARTIN SR. 2004 (Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**₩** M 2□ F Days Hours Yrs. Director 239-34-5818 73 May 31 1931 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "naturel", or iteme 23a or 28e-1 show other treumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Directo DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 917 Hamilton Street N.E. U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after Tyes 2□No Army Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 Is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Postal Worker Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Evelina McMillan Daniel Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Deportment of Health and Importent: If item 27 is m any injury or other treum ance. 917 Hamilton Street N.E. Washington DC 20011 Geraldine Martin/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 7/31/2004 Brentwood, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBRO NECLAR Pnysician 4DAYS disease or condition resulting in death) /Medical **Examiner** EARS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine e attending physicion and did for use as the windly ansi Due to (or as a consequence of): Physician/Medical foruse as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ola de þ DISORDER 1 Yes 2 No 3 Probably 4 Unknown ARRHYTHMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Comple autopsy performed? 211No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient PER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Singantinear GAITHERSBURG MD: 20878. 30. Name and address of person who completed cause of death. Item 23a) (Type, Print) 1 (FS) (1) N (FIN) 23) (Type, Frint) 2 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 9 2004 Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 25000 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** July 23, Day 2004 Year 10:00 A M MOBLEY SARAH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Ritchie Hospice Baltimore City
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Washington, GA 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1□M 2√2F 90 Yrs. Director 579-24-9853 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location itam 27 is markad othar than "natural", or itams 23s or 28s-f show other traumatic evant, it a Madical Exemples must be notified at 10d. Inside City Limits Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 "G" Be Completed by Funeral Street, N.E. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes Ano Specify: 3 Widowed 4 □ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Dietician Wash Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carry Simpson ပ္ Henry Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a 917 N Eden Street Baltimore, Md. 21205 Catherine Holly/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 7/29/04 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ŏ 4 ☐ Donation 5 ☐ Other (Specify) National Harmony Memorial Landover, Maryland 21. Signature di Funeral Service Licensee 22 Name and Address of Facility
Frazier's Funeral Home, Inc. e, or p mp ick time that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. 389 R.I. Ave., N.W. Wash., DC 20001 23a. Part1. Enter the Isease, shock, or heart I lure. L Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GASTric cancer year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform rmed2 2 ☑ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Definer (Specify) No 100 1 Yes 2 No Certification: To 27. Manner of Death 1 2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who complete: cause of death (Item 23a) (Typ= rint)

E. Tso MD Ri by H-sp ce N. Entaw St 31. Date filed (Month, Day, Year) Registrar's Lignature State JUL 3 0 2004 Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Vital Records,

of

Division

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year July Santo Charles 6:18 p Messina 27 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 € M 2 □ F 95 Director 579-01-4408 May 17, 1909 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, It e Maylical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 Robinson Road 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after Yes 2 □ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify. 3 XWidowed 4 □ Divorced Year or Dates: 1944 white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) unknown courier communications permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any Injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles ပ္ Messina Rosa Guaulise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Robinson Road, Huntingtown, MD Charlotte M. Martin, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7-29-04 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Cardiac 15 minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): more thon Examiner Corclio Vasiular disease therosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death Division of Vital Records, P.O. 1 Yes 2 No 9 Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 🗗 Unknown Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) turana, D. 50653 7-27-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN. C Deale Churchton Road -Deale mp. 31. Date filed (Month, Day, Year) 32. Registra Signature State Blever & Sparke Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. Nø. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 832m 29 dred J. Marshall 2004 Jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cambridge Chesapeake Woods Center Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 0 F 216-38-9581 Director 88 March 27, 1916 Maryland Usuel Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show if Health and Menial Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, it a Micdical Examinar must be notified at 1 Yes 2 No Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Leonard Lane 21613 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2No white Completed by Specify: 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George W. Sellers Sadie Turner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Kramer daughter 1019 Hudson Road, Cambridge, MD21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages 1
Department of H
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any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 8/1/04 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VANCEI **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sementially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Box 68760 the attending physicien Completed by Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown O 9□ Unknown ۵ م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Pg 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? certificate 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မှ 2 ER/Outpatient 1 Inpatient 3 DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death. I Director: After to 28b. Time of Certification: 28d. Describe how injury occurred 1-Antural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifies Medical and manner stated. the 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an completed cause of death (Item 23a) (Type, Print) 302 Cullins Huslock n ws 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 500 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death McCown Day Grace 11:22 AM 2004 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 22,2004 Birthplece (State or Foreign Country) Months Days 5 1□M 20F Hours 4 days (unknown) Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12302 Hungerford Crt. 21770 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify:White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Christopher McCown Jill Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12302 Hungerford Crt. Monrovia, MD 21770 Christopher McCown / Father 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) July 30, 2004 Frederick, MD Frederick Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike Frederick, MD 21702 20a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due of (or as a consequence of): Left Heart Syndrome Darctation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 st Department of Health and Importent: If itam 27 is n any injury or other traun once.

Physician

/Medical

Examiner

10a, State

Director

Completed by Funeral

Be

Funeral

Director

itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after death with in and Mental Hygiene.
Is marked other than "natural", or Itams 23a or?

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

the Maryland

The law requires that the death certificate be executed attending physician and for use as the burial-transit

ed by the detached

s been signer should be d

certificate has b irector, page 2 s

After this c

Diractor: /

within 24 hours after d To the Funeral Direct completely filled in by

tha Hospitel or Attending Physician:

signed by

Examine Physician/Medicai Completed by Be ဥ Certification;

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

of corpus callosum, polydactyly intrauterine arough retardation

24a. Was an Yes 2 No

1 ☐ Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

28b. Time of Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 Could not be determined

29c. License number D50902 29d. Date signed (Month, Day, Year) July 26, 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9901

Tafolla MU
32. Registrar's Signature Medical Conter Drive Rockville, Maryland 2085 Kimberly AUG 0 31. Date filed (Month, Day) 3 2004

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

	1	For State Registrar	State	e of M	laryland / De	epartmen Certificate			•	201	11.	25006
Physician		1. Decedent's Name (First, Stephe		ł M	auk		<i>3</i> 0, 2	<i>-</i>	2. Date of De Month July 30	Reg. Nó. U (ath Day 2004	Year	3. Time of Death
/Medical Examiner	_	4a. Facility Name (If not ins				4b. City,	Town, or	Location of Death		4c. Count	of Death	5:00 A M
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Funeral Director		5. Social Security Number 214-42-6613	6. Sex 1 ⊠ M 2□		ge (In yrs. last birtho	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da June 1	1, 1944	9. Birth Cou Alal	place (State or Foreign Intry) Dama
land ow	-	Usual Residence of Deceder 10a. State 10b. C			10c. City, Town o	or Location						10d. Inside City Limits
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with the Mar a or 28e-1 si the netified	Ē	10e. Street and Number	marnock Wa	17 Δn	+ T	10f. Zip	Code 0874			10g. Citizen of		•
of the death virtues and the control of the control	e e	11. Marital Status	12. Was i					spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	Unite	e - Ameri	can Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28s-1 show ship hipty or other treumetic event, the Medical Examinational Long. To Be Completed by Funeral Director		1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 🖾 Div	Married 1 TY	es 2 🔀 , Give or Dates:	No	1 ☐ Yes 2		Specify:	o Rican, etc.)		ck, White, v: Whi	
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or mynjury or other treumetic event, the Madical Exercit ance. To Be Completed by F		15. Dec (Specify only i	edent's Education highest grade complet	ed)	(6	ecedent's Usua Give kind of wor	k done d	uring most of wor	kina	16b. Kind of B	usiness/In	ndustry
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Ma and 2 s alth an 27 le s		Kimberly M.		Daugl				Rd Mt A			State, Zip	Code)
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Bal permi Depa Impo eny la		> 8	M			3401 B1	Lader	nsburg Ro	oad Bre	n runer ntwood	мD 20	ome 0722
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Physician / /Medical		disease or condition resulting in death)	a	to (or as	a consequence of):	CAN	(8	R			1	Mouth
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Division of Vita Division of Vita To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certification prompile of the funeral director, Medical Certification; To Be C		3 Suicide 6 C 4 Homicide	ould not be stermined 28e. Pt	ace of Inj	ury - At home, farm, c. (Specify)	street, factory,	office		28f. Location (SI City or Town	reet and Number, State)	er or Rural	l Route Number,
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o the Hosp ithin 24 hou on the Fune ompletely fil		one)	and n	e basis of anner sta	r examination and/or	r investigation, i	n my opir	nion, death occurr	red at the time, d	ate and place, a	nd due to	the cause(s)
with To Con	2	29b. Signature and title of ce	rtifier	1	7	29c.	License I	number	2	9d. Date signed	(Month, L	Day, Year)
10 (2)	3	0. Name and address of pe	rson who completed c	ause of d	leath (Item 23a) (Typ	رل ا	,01	010		1001	501.	1004
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	Dhusisi		1. Decedent's Name (First, Middle, Las							2. Date of Month		Day Y	ear	3. Time of Death	
4	Physici /Medic		Robert	Ja	cksor	1	Max			Augu	st 3	, 2004		11:00A M	
	Examin	er	4a. Facility Name (If not institution, give						Location of Dea	th		4c. County of			
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be inclified	i Director	10e. Street and Number 8907 Cheltenham Avenue					Code 2073	35		10g. 0	og. Citizen of What Country? U.S.A.			
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Baltimore, Maryland 21215-0036	urs after al', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 Armed Forces? If Yes, Give Year or Dates:	ło	- 1	1 ☐ Yes 2		Specify:	to Ricari, etc.)	Rican, etc.) Black, Specify:			White, etc. White	
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and	lbe fi	Be	17. Father's Name (First, Middle, Last) Samuel D. Max	ey, Jr.						ta Mary					
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ē,	Heal Heal tem		Ruth Ann Maxey (20a. Method of Disposition	wrie)	20b. P	lace of Dispo	sition /Nam	ne of	1	Date	-	Location - Cit			
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O. Box 68	ne death certificate be executed the attending physician and hed for use as the burial-transit	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown						-	23d. Date of delivery Month Day Yea			
P.O.	w requires that the de been signed by the s should be detached	Ph	Part II. Other significant conditions or	entributing to death bu	ıt not resu	ulting in the u	nderlying ca	ause giver	n in Part I.	23e. Di	d tobacco	use contribu	te to the	cause of death?	
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COL	w req beer shou	Completed	24a. Was a								as an	24b. Wer	e autons	sy findings available	
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tal	iclan: Th certificate rector, pag	ø	25. Was case referred to medical						26. Place of De	1 ☐ Yes		10	Yes 2	□ No	
>	Phyaician: this certific ral director,	To B	evaminer?	Hospital: 1 ☐ Inpatie	nt 2 🗆 1	ER/Outpatien	t 3 DO	Other	-	fome 5 X Re		6 □Other (Specify)		
o uo	Attending Ph or death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	M 28	8c. Injury Work? 1 🗆 Ye	at ? es 2 □ No	28d. Describ	e how inj	ury occurred			
Division of Vital Records,	i i i i i	Certification:	3 Suicide 6 Could not be 4 Homicide determined							28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	e Hospital of 24 hours at e Funeral Dietely filled i	edical C	29a. Certifier 1. Certifying Phy (Check only one) 2 Medicel Exem	/sicien: To the best of iner: On the basis of and manner sta	examinat	wledge, death tion and/or inv	occurred a restigation,	at the time in my opi	e, date and place nion, death occu	e, and due to the time	e cause(e, date ar	s) and manne nd place, and	r as stat due to t	ed. he cause(s)	
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-	BBI		30. Name and address of person who callex Leon M.	D. 3261	01d V	Washin	gton l	Road	Suite 3	010 Wa	dorf	- Mars	land	1	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 4	32. Regiera	r's Signat	ture	Speed	2		510 mu.		- , Hary	Tang		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 201State of Maryland / Department of Health and Mental Hygiene for Amend Item 2065tate of Wary
1-Registrar WCHD/SH 8/5/04 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Vear 1:55 AM Vivian Lorraine Taylor Marshall July 29 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1911 Dual Highway Washington Hagerstown
If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) South 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□M X F 49 Director 247-08-9050 March 15. 1955 Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Completed by Funeral Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1911 Dual Highway death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. filed within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unit Manager Credit Card Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Hant: If item 27 is marked of unknown ပ Shirley Davis Campbell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1911 Dual Highway Hagerstown, Maryland 21740

20b. Place of Disposition (Name of commetery, crematory or other place)

July 31,04 Samuel J. Marshall/husband 20a. Method of Disposition 20c. Location - City or Town, State To Ho 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Smithsburg Crematory July 20, 94 Smithsburg, Maryland 21. Signature Fun ral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 0 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Nonsecretory Carcinoro Tumos Immediate Cause (Final **Physician** astatic disease or condition year resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown page 2 should been 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No this certificate has 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attence within 24 hours after death To the Funeral Director: the f 6 Could not be determined 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled it Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 134288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

aserstown MO 217 LO

1130

32. Registrar's Signature

Angela Manns, MD 31. Date filed (Month, 1967) 2 2004

			For Stete Registrar	State of Maryl	and / Dep	artment rtificate	t of H	ealth a		ental Hyg	eg. No.	2004	25999	
	Physici	an	1. Decedent's Name (First, Middle, Last) Lucille	Elaine MUR	RAY					2. Date of Dea Month	Day	Year	3. Time of Death 1 10:32 AM	
	/Medio Examir		4a. Facility Name (If not institution, give s Washington Count	treet and number)				Location of	of Death	July		200 4 Sounty of Dea Vashing	ith	
	Funeral Director		214-10-1319	7. Age (In)	rs. last birthday) 82 Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day Oct. 9,	Year) 192	9. Bir C 1 Mar	thplace (State or Foreign ountry) cyland	
	yland low		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits	
	8a-f el	ctor	Maryland Washingt	on	Hagerst								1X∑Yes 2 No	
	3e or 2	Dire	750 Dual Highway			10f. Zip	217	40		1		on of What Co $S.A.$	ountry?	
980	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "naturel", or Items 23e or 28e-f ehow event, the Medical Examination for the rediffical at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Model 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe	ecify Yes or No- Rican, etc.)		I. Race - Ame Black, Whi Specify: W	te, etc.	
15-0	n 72 ho "natur	leted	15. Decedent's Edu (Specify only highest grade	completed)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa	ition Juring most	of worki	ng	16b. Kin	d of Business	/Industry	
21215-0036	d withi giene. er then	Completed by	Elementary/Secondary (0-12) unknown	College (1-4or 5+) unknown		nomema					1	ner own	n home	
Maryland	should be filed within nd Mental Hygiene. marked other then umatic event, the M	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Hilby Mi	11s				18. Mothe	r's Name	(First, Middle, I			5	
	ith all		19a. Informant's Name/Relationship (Ty.) Dennis Murray — so							Aoute Number Hagersto				
Baltimore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R ' 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	b. Place of Dispo cemetery, cre (agersto	matory or of	her place		Ju1	y 31, 004		ation - City or	Town, State	
Balti	permit. Pages Department of h Importent: If ite any injury or of		21. Signature of Funeral Service License	rtal		2. Name and			y Mi	nnich Fu 1, Hagen	inera	1 Home	2	
	hysician and hysician and the burial-transit	Physician/Medical Examiner	Ä	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary Lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	dear	e of dying	aule	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death I Heow
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	⊒Ectopic pre □ Other (spe					23	d. Date of de Month	livery Day Year	
rds, P	luires that n signed b ıld be deta	by	Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa							23e. Did tobacco use contri			bute to the cause of death? 3 Probably 40 Unknown	
		Completed									24a. Was an autopsy findings prior to completion of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No \(\text{No} \)			
Vital	Phyeicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	iospital:	Erno.		Othe	and the same of th		(Check only on				
of	ling After unel	-	1 Yes 2 No ' 27. Manner of Death 15 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	2 ER/Outpatier 28b. Time of Injury		Bc. Injury Work	4 🗀 1401	2	ne 5 🗆 Reside 28d. Describe ho			cify)	
Division	al or Attendii safter death. I Director: A id in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	t home, farm, st ecify)	reet, factory,	, office		2	28f. Location (St City or Town		Number or R	ural Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in 5	edical (29a. Certifier (Check only one) 2 Medical Exemit	sicien: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ca	ause(s) a ate and p	nd manner as lace, and due	s stated. e to the cause(s)	
2		W	29b. Signature and title of certifier Manyferr	y shoet			License				2/2	. 1.0	h, Day, Year)	
DY.	-2). SHAM	1tem 23a) (Type,	Print)	81-1	cet	Ne	rgesto	mi	MP	21740	
	Sta Registi	•	31. Date filed (MontiAUGYO) 2 20	32. Pagistrar's Si	gnature	berle				V				

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** Month August 2, McHale 1:30 P John Edward /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4304 Skyline Drive Suitland
If Under 1 Year | If Under 24 Hrs. Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**XM 2□ F Yrs. Director 452-36-6654 78 09/11/1925 Texas Usual Residence of Decedent init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural; or items 23s or 28a-1 show injury or other traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits Maryland Prince George's 1 ☐ Yes RNO Director Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 Skyline Drive 20746 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

120 yes 2 □ No 1749s, Give Year or Date 946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X XMarried Baltimore, Maryland 21215-0036 1943-1 ☐ Yes 2√√No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Agent FBT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Edward McHale Robbie Kennedy Scoggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. McHale / Wife 4304 Skyline Drive Suitland, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Resurrection Cemetery 08/06/2004 Clinton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur uneral gervice 22. Name and Address of Ference P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part / Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) mediate Cause (Final Physician OF 18rhosis /Medical Due to (or as a consequence of): Examiner failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? VPOTension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has certificate 1 ☐ Yes 2 ☐ No 1 Yes 2**√ X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 4 ☐ Nursing Home ★XResidence 6 ☐ Other (Specify) this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director; After 5 Pending investigation 1 X Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a **XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0052999 3/2004 MD allunace 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali Rahimian MD 7501 Surratts Road #205 Clinton, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2004 Registrar